United Nations ST/IC/2001/27

Secretariat

10 April 2001

Information circular*

To: Members of the staff

From: The Under-Secretary-General for Management

Subject: **Visa status in the United States of America**

1. The purpose of the present circular is to provide additional information on the conditions of application of administrative instruction ST/AI/2000/19 (Visa status of non-United States staff members serving in the United States, members of their household and their household employees, and staff members seeking or holding permanent resident status in the United States). Staff members should familiarize themselves thoroughly with the provisions of that instruction. It is available on the Intranet, where it can be accessed under "reference material".

2. Questions pertaining to G-4 visas are covered in section I of this circular (paras. 3-25). Section II concerns questions relating to permanent resident status, in respect of staff members at the time of recruitment or while employed (paras. 26-30) as well as former staff members after separation from service on a G-4 visa and certain of their relatives (paras. 31-32). Section III deals with G-5 visa questions (paras. 34-52).

Section I. G-4 visas

What is a G-4 visa and who is eligible for it?

3. The G-4 visa is a non-immigrant visa granted to officials or employees of international organizations while stationed on official business in the United States of America, as well as to members of their immediate families. The United States authorities grant a G-4 visa in order to permit staff members who are not citizens or permanent residents of the United States to work at United Nations Headquarters in New York or in other locations in the United States.

4. The immediate family of a staff member eligible for a G-4 visa include a spouse, unmarried dependent children under the age of 21 and children for whom a staff member receives an education grant.

5. Other relatives, including children who are 21 years old or older for whom the staff member does not receive an education grant, may be eligible for a G-4 visa

* The present circular will be in effect until further notice.

01-32888 (E) 260401

when they demonstrate close ties and a continued dependency on the staff member. It must be established that they seek entry to the United States in order to reside with the staff member. This excludes applications that are submitted for other purposes, such as study, the pursuit of business or employment opportunities. Applications for a G-4 visa for relatives other than the immediate family of the staff member are submitted to the United Nations Visa Committee, and subsequently to the Assistant Secretary-General for Human Resources Management for approval.

6. The Visa Committee will generally give favourable consideration to applications by relatives previously living in the staff member's household before coming to the United States and for parents who are over the age of 65. If the relative was not previously living in the staff member's household, the staff member will be required to explain the compelling reasons for which the relative would now join his or her household. If the relative is not financially dependent on the staff member, the staff member will be required to justify the request on other compelling grounds, such as physical need for family care in the case of parents, or incapacity or minority in the case of siblings.

Application for G-4 visas

7. For staff members who are newly recruited to New York, or assigned or transferred to New York from another duty station:

(a) The Human Resources Officer handling the recruitment or the Executive Officer handling the assignment or transfer prepares an application for G-4 visa(s) for the staff member and his or her immediate family members;

(b) The Office of Human Resources Management or the executive office submits the application to the Chief of the Travel and Transportation Service, Office of Conference and Support Services;

(c) The Chief of the Travel and Transportation Service issues a formal request for issuance of a G-4 visa for the staff member and immediate family members to the appropriate United States consular office where the visa will be granted.

8. For staff members already in the United States who seek conversion of a prior visa to G-4 status for themselves or members of their immediate family:

(a) The staff member obtains form PT.63* (request for change to G-4 visa status) or form PT.63/A* (request for change to G-4 visa status for spouse and family members) and submits the completed form to the Human Resources Officer;

(b) The Office of Human Resources Management transmits the request to the Chief of the Travel and Transportation Service for transmittal to the United States Mission.

9. For staff members requesting a G-4 visa for relatives other than immediate family members:

(a) The staff member obtains form TTS.1,* and forms VC.3 and VC.4 from the secretariat of the Visa Committee, and submits the completed forms to the secretariat of the Committee, together with evidence of health insurance;

* Available on Intranet, Quicklink "Forms".

(b) If the request is approved, the Visa Committee secretariat transmits completed form TTS.1 to the Chief of the Travel and Transportation Service together with evidence of health insurance;

(c) The Chief of the Travel and Transportation Service issues a formal request for issuance of a G-4 visa to the United States consular office where the applicant will appear in person;

(d) A copy of the request is given to the staff member for transmittal to the relative. The staff member should advise the relative to go to the United States consular office with a valid national passport in order to obtain the visa. The relative may not apply for, or accept, any other type of visa while awaiting issuance of a G-4 visa.

Duration of authorized stay and extension of G-4 visa

10. The duration of the G-4 visa and the number of entries granted by the United States authorities depend on a number of factors, including the contractual status and nationality of the visa holder.

11. When a staff member or a family member to whom a G-4 visa has been granted arrives in the United States, the immigration official generally records "G-4, D/S" on United States Government form I-94 (permission to stay, arrival-departure record), which is stapled into the passport. This notation establishes the G-4 visa status as valid for as long as the staff member remains in the employ of the United Nations and does not leave the United States.

12. However, if a specific expiration date for the G-4 visa status is recorded on form I-94, and the staff member is required to remain on duty in the United States beyond the specified date, the staff member must request an extension by writing a memorandum to the Chief of the Transportation and Travel Service through his or her executive office. Extension requests for relatives other than immediate family members should be submitted to the Visa Committee secretariat. All requests for an extension should be presented at least 30 working days before the expiration date specified on the I-94 form.

Request for renewal of G-4 visa in case of travel and re-entry into the United States

13. Before leaving the United States on official or personal travel, staff members and their family members on a G-4 visa should make sure that the G-4 visa stamped in their passports will still be valid on the expected date of re-entry. If not, they will have no valid document for re-entry as the I-94 form is removed upon departure from the United States.

14. If the G-4 visa has expired, and there are at least 15 working days before departure from the United States, a new G-4 visa for the staff member and immediate family members should be requested as follows:

(a) The staff member obtains form PT.61,* completes it in duplicate and submits it to the executive or administrative office, with the national passport or the United Nations laissez-passer;

* Available on Intranet, Quicklink, "Forms".

(b) The executive or administrative office certifies the completed forms;

(c) The staff member hand-delivers the completed forms, together with the passport or laissez-passer, to the Travel and Transportation Service, which will forward it to the United States Mission.

15. If there are less than 15 working days before departure from the United States, a new G-4 visa for the staff member and immediate family members should be requested as follows:

(a) The staff member obtains form TTS.1,* completes the form, obtains certification of the form from the executive or administrative office and submits it to the Travel and Transportation Service;

(b) The Travel and Transportation Service gives to the staff member a copy of the facsimile request addressed to the appropriate United States consulate or embassy abroad where that copy will have to be presented in order to obtain a new G-4 visa.

16. Requests for new G-4 visas for relatives other than immediate family members should be submitted to the Visa Committee. The Visa Committee secretariat transmits endorsed requests to the Chief of the Travel and Transportation Service.

Expiration and cancellation of G-4 visas

17. When a staff member separates from service, goes on special leave with or without pay, or is transferred to a duty station outside the United States, his or her right to stay in the United States expires automatically, even if the G-4 visa stamped in the passport shows a date of validity beyond the date of separation or transfer. The same applies to family members whose G-4 visa status is derivative from the status of the staff member.

18. Staff members are required to comply strictly with the procedure set out in section 3 of ST/AI/2000/19 for cancellation of G-4 visas for themselves and their family members prior to the effective date of their separation from service, special leave or transfer. This must be done, **at the latest**, one week prior to that date. Visas that have already expired do not have to be cancelled under that procedure.

19. Staff members who have obtained a G-4 visa for a spouse from whom they are subsequently divorced are required to follow the procedure prescribed in section 3.3 of ST/AI/2000/19.

20. During the exit interview required before departure, staff members will be requested to confirm that they have followed the visa cancellation procedures and provide a photocopy of the cancelled or expired visas.

21. In practice, United States authorities allow staff members and their families 30 days to leave the country or adjust their status after the date of expiration of their G-4 visa. If additional time is required, the staff member should contact the Office of Host Country Affairs at the United States Mission without delay.

22. In the event of the death in service of a staff member with G-4 status, the Staff Counsellor may be contacted for guidance in requesting extension of the normal 30-day period for surviving family members who are on derivative G-4 visas.

* Available on Intranet, Quicklink "Forms".

Permission to work for holders of derivative G-4 visas

23. Employment of spouses and dependent children who are on derivative G-4 visas is generally authorized, within certain limitations. Employment is not authorized for other relatives who may also have a derivative G-4 visa. Unmarried children who are less than 23 years old and are full-time students seeking to work part time during the academic year, or full time during school holidays, are normally authorized to do so without limitations. Children on G-4 visas who have reached their twenty-third birthday will not be authorized to work unless they are physically or mentally disabled.

24. The necessary information and forms to seek authorization to work may be obtained from the Staff Counsellor's office. Requests for permission to accept employment must be submitted to the United States Immigration and Naturalization Service through the United States Mission. Permission is required before employment begins. It may be granted for a maximum period of three years and may be renewed. A new request must be submitted upon each change of employment.

25. All income earned in the United States by holders of derivative G-4 visas is subject to income and social security taxes.

Section II. Permanent resident status
For staff members at the time of recruitment or while employed

26. Under section 5.6 of ST/AI/2000/19, non-United States citizens who have permanent resident status in the United States are required to renounce such status and to change to G-4 visa status upon appointment. The same rule provides that staff members who seek to change to permanent resident status will not be granted permission to sign the waiver of rights, privileges, exemptions and immunities required by the United States authorities for the acquisition or retention of permanent resident status. The provision is based on a policy established in 1953 by the General Assembly that persons in permanent resident status should in future be ineligible for appointment as internationally recruited staff members unless they are prepared to change to a G-4 visa status (or equivalent status in host countries other than the United States of America). That policy was adopted because it was considered that a decision to remain in permanent resident status in no way represents an interest of the United Nations. On the contrary, to the extent (if any) that it may weaken existing ties with the country of nationality, it is an undesirable decision.

27. The general rule stated in section 5.6 does not apply in a limited number of situations, which are strictly defined in section 5.7 of the instruction.

28. The most frequent situation will arise in New York in respect of locally recruited staff members in the General Service and related categories, who are authorized to retain their permanent resident status on recruitment, or to acquire that status in the course of their service with the Organization. Those who are newly recruited will be asked to produce their alien registration card for the Office of Human Resources Management on the day they report for duty. Staff members who have already been recruited and wish to acquire that status are required to do the following:

(a) Advise the Office of Human Resources Management in writing prior to making their application to the authorities of the United States;

(b) If the application is successful, sign a waiver of rights, privileges, exemptions and immunities, as required by United States authorities. The staff member must request authorization to do so from the Office of Human Resources Management;

(c) Immediately inform the Office of Human Resources Management in writing of the date of signature of the waiver and produce his or her alien registration card.

29. Acquisition of permanent resident status places staff members in a position of parity with staff who are nationals of the United States with respect to their status and entitlements in the United Nations, including home leave, education grant and repatriation grant, from the date on which they have been granted permanent resident status as shown on their alien registration card.

30. Permanent residents are subject to all applicable United States laws and are liable to pay income taxes on their United Nations earnings. They are not, however, eligible to contribute to the United States Social Security Programme and do not pay social security taxes. Staff members authorized to sign the waiver of rights, privileges, exemptions and immunities required by the United States Government become eligible to obtain tax reimbursement on their United Nations earnings under staff regulation 3.3 (f) and ST/AI/1998/1 as from the date of the signature of the waiver. For that purpose, they are required to follow the procedures contained in the information circular on payment of income taxes that is issued annually by the Controller.

For former staff members after separation from service on a G-4 visa, and certain of their relatives

31. The following table provides information on some essential conditions under which former staff members previously serving on a G-4 visa, and certain of their relatives, may be allowed to change their visa status. **Please note that the information is subject to change at any time by the United States authorities.**

Category	*Required residence and physical presence in the United States*	*Application deadlines*
A. Eligible for "special immigrant" status:		
(1) Unmarried son or daughter of official on G-4 visa	On a G-4 or N visa: (a) ½ of the 7 years before date of application; and (b) 7 years* between ages 5 and 21	25th birthday
(2) Surviving spouse of deceased official formerly on G-4 visa	On a G-4 or N visa: (a) ½ of the 7 years before date of application; and (b) 15 years* before death of official	6 months after death of official
(3) Retired official formerly on G-4 visa	On a G-4 visa: (a) ½ of the 7 years before date of application; and (b) 15 years* before date of retirement	6 months after retirement
(4) Spouse of a retired official granted special immigrant status under A (3) who accompanies or follows official as member of immediate family	None	None
B. Eligible for "N" category non-immigrant visa:		
(1) Parent of child granted special immigrant status under A (1) until child becomes 21	None	None
(2) Child, until age 21, of parent who is granted:		
– "N" visa under B (1); or	None	None
– Special immigrant status under A (2), (3) or (4)	None	None

* These amounts are totals, and need not constitute a continuous period.

32. **Neither the Office of Legal Affairs, nor the Office of Human Resources Management is staffed to provide advice or assistance as to the status of non-United States staff members, former staff members or relatives wishing to stay in the United States on a basis other than on a G-4 visa. Staff members should seek the advice of competent immigration lawyers.**

Section III. G-5 visas

33. The information provided below should be read in conjunction with sections 6 to 10 of ST/AI/2000/19, which contains the applicable rules.

What is a G-5 visa and who is eligible for it?

34. A G-5 visa may be granted to household employees of staff members who hold a G-4 visa. This is not part of the benefits extended to staff members but a privilege granted by the host country to serve the interests of the Organization. The employment of household help under a G-5 visa is subject to the laws and

regulations applicable to employment contracts in the United States of America and the specific state concerned. A staff member employing such household help is responsible for compliance with these laws and regulations. The United Nations will not assume any liability arising from or relating to such laws and regulations or any legal actions in connection with the employment of household help by any staff member.

35. A G-5 visa will not be granted if the prospective employee is related to the staff member or his or her spouse, or has no previous experience in domestic service. The employee should come from the same cultural background as the staff member, or have several years of documented domestic service in the staff member's household. A G-5 visa cannot be used for any other purpose for which the United States authorities grant another type of non-immigrant visa category, such as study, business, tourism or specific employment.

Application for a new G-5 visa

36. A valid G-5 visa is required for the household employee to enter the United States. Staff members wishing to obtain a G-5 visa for a household employee are required to submit an application to the United Nations Visa Committee, which will provide advice to the Assistant Secretary-General for Human Resources Management.

37. The staff member should obtain from the Visa Committee secretariat a complete set of application documents. A completed application consists of:

(a) A signed undertaking by the staff member;

(b) A request for endorsement of the G-5 visa application, with all necessary attachments;

(c) A standard employment contract, to be signed by the staff member and the household employee. The contract must be in English and, if the employee does not understand English, in another language that the employee understands;

(d) A signed form TTS.1* (request for United States visa). However, if the prospective employee is in the United States on another type of visa, form PT.63/B* (request for change to G-5 visa status [for household employee]) should be submitted. In those cases, the United States authorities may not consider adjustment of visa status unless the prospective employee applies from outside the United States;

(e) If the staff member has previously employed a G-5 visa holder, records concerning the previous employee should be submitted as well.

38. The Visa Committee secretariat transmits endorsed requests to the Chief of the Travel and Transportation Service for transmittal to the United States authorities.

Obligations of the staff member employing a G-5 visa holder

39. On arrival in the United States of the household employee to whom a G-5 visa has been granted, the staff member is required to inform the Visa Committee secretariat and the Travel and Transportation Service by submitting a form entitled "Clarification of status of household employee", available from the Visa Committee

* Available on Intranet, Quicklink "Forms".

secretariat, together with a copy of the signed contract of employment, a copy of the G-5 visa and of United States Government form I-94.

40. As the household employee is subject to United States laws on taxes and social security while holding a G-5 visa, unless there is a totalization/social security agreement between the United States and the country of nationality of the household employee, staff members are required to withhold income, social security and state taxes from their household employees and to submit them, together with their own share of social security contribution, to the appropriate tax authorities.

41. Special rules regarding income tax and participation in the United States Social Security Programme apply to household employees of senior United Nations officials at the Assistant Secretary-General level and above, as a result of the provisions of the Convention on the Privileges and Immunities of the United Nations and of the Vienna Convention on Diplomatic Relations. Those rules are set out in section 10 of ST/AI/2000/19.

42. All staff members are required to provide adequate health insurance coverage for their household employees. The United Nations will assume no responsibility in this regard, or in assisting staff members who have incurred medical expenses on account of their household employee.

43. Staff members employing a G-5 visa holder are required to maintain the records listed in section 6.3 of ST/AI/2000/19 **for the duration of actual employment and for three years thereafter.**

44. At the end of the authorized employment or on cancellation of the employee's G-5 visa, the staff member is responsible for making arrangements for the repatriation of the employee. Evidence of such repatriation, including original boarding passes or a copy of the passport of the employee stamped upon arrival in the home country, must be submitted to the United Nations Visa Committee.

45. If the household employee ceases to be employed by the staff member and is to be employed by another staff member on a G-4 visa, both staff members must inform the United Nations Visa Committee of the proposed change, as provided in section 7.3 of ST/AI/2000/19. The new prospective employer will then submit an application for G-5 visa, following the procedure set out in paragraph 37 above. Pending approval, or in the absence of approval, the responsibility to repatriate the household employee remains with the original employer.

Duration of authorized stay and extension of G-5 visa

46. The duration of authorized stay is indicated in the I-94 form, which is stapled into the passport by a United States Immigration and Naturalization Service official upon the arrival in the United States of the household employee to whom a G-5 visa has been granted. Staff members are urged to review the I-94 form in their employee's passport to ensure compliance with all applicable rules.

47. If the household employee wishes to remain in the United States beyond the period authorized by the I-94 form, an extension of authorized stay must be obtained. This should be done as follows:

(a) The staff member obtains from the Visa Committee secretariat United States Government form I-539 (application to extend time of temporary stay);

(b) The staff member submits the completed form, together with the household employee's I-94 form and a certificate that the staff member still holds a G-4 visa and continues to employ the household employee;

(c) The Visa Committee secretariat transmits the completed application to the Travel and Transportation Service for transmittal to the United States Mission.

48. Household employees who have overstayed the authorized period, as indicated in their I-94 form, will be obliged to leave the United States and will not be eligible to be readmitted into the United States without first having obtained a new G-5 visa in their country of nationality. United States authorities have made a limited number of exceptions to the requirement that a new G-5 visa should be obtained in the country of nationality, in particular:

(a) If an application was filed on behalf of a household employee prior to the expiration date shown on the I-94 form, but was not approved by the United States authorities until after that date, the employee will not ordinarily be required to return to his or her country of nationality to obtain a new G-5 visa;

(b) A G-5 visa applicant who has a current residence in a country other than that of his or her nationality or the United States will have the option to apply for his or her visa in that country;

(c) G-5 applicants from a country where the United States does not have a visa-issuing post may apply in certain countries designated by the United States Department of State.

Cancellation of G-5 visa

49. Staff members are required to comply strictly with the provisions of section 8 of ST/AI/2000/19 concerning the cancellation of their household employee's G-5 visa when household employment is terminated or when the staff member is no longer eligible for a G-4 visa, as will occur upon separation from service, transfer to a duty station outside the United States, or change from G-4 to another visa status.

50. The staff member is required to submit the following documentation at the latest within one week before his or her change of visa status:

(a) The passport of the household employee holding the G-5 visa, so that the visa may be cancelled;

(b) The employee's I-94 form.

Those documents must be presented either to the United States Mission, or to the Travel and Transportation Service, which will transmit them to the United States Mission for processing.

51. Upon cancellation, the staff member is required to submit copies of the cancelled documents to the Visa Committee secretariat.

52. The staff member is responsible for making all necessary arrangements for the repatriation of a household employee whose G-5 visa has been cancelled and for submitting proof of repatriation to the Visa Committee secretariat.

United Nations ST/IC/2001/28

Secretariat

17 April 2001

Information circular*

To: Members of the staff

From: The Assistant Secretary-General for Human Resources Management

Subject: **Placement and promotion list for staff in the Professional category and above**

1. The purpose of the present information circular is to inform staff members of recommendations made by the appointment and promotion bodies that have been approved by the Secretary-General in respect of placements and promotions.

2. This list, which includes staff in the Professional category and above, is issued monthly to enhance transparency and to enable the staff to perceive improvements in gender balance throughout the Secretariat.

3. In order to ensure equitable treatment in promoting staff members, implementation will continue under the terms of administrative instruction ST/AI/1999/8 on placement and promotion, i.e., effective the first day of the month following approval by the Secretary-General, subject to the availability of the post and the assumption of the higher-level functions.

4. The attached list include placements and promotions approved in March 2001.

* Expiration date of the present information circular: 31 December 2001.

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Annex

Placement and promotion
1 to 31 March 2001

Name	*Gender*	*Releasing department/office*	*Receiving department/office*	*Post level*	*Vacancy number*
Promotion					
Bandaogo, Christophe[a]	M	ECA	ECA	P-3	00-Y-ECA-00X097-E-TA
Barnido, Asuncion[a]	F	DM/OPPBA	DPKO	P-3	00-A-DPK-001348-I-NY
Calret, Francesc[a]	M	DDA	DDA	P-3	00-P-DDA-001455-I-NY
Fischer, Gisela Cornelia	F	DPI/UNIS	UNOV	P-3	00-A-UNV-622-VI
Mangue Nnandongo, Guillermo	M	ECA	ECA	P-3	00-Y-ECA-00X098-E-LM
Marcedo, Joao[a]	M	DM/OPPBA	DM/OCSS	P-3	00-A-DOM-001523-I-NY
Morande, Juan	M	ECLAC	ECLAC	P-3	98-ECL-351-SC
Roman, Juan Alberto	M	ECLAC	ECLAC	P-3	99-F-ECL-00X330-I-SC
Salazar Van Epp, Andres Daniel	M	DPA	DPA	P-3	00-P-DPA-001103-I-NY
Beswick, Janett[a]	F	DGAACS	DGAACS	P-4	00-A-DGA-001299-I-NY
Cohen, Joel[a]	M	DPKO/FALD	DPKO/FALD	P-4	00-F-DPK-001206-E-NY
Erdembileg, Sarangerel	F	DESA	DESA	P-4	00-S-ESA-001342-I-NY
Kovacs, Karoly	M	DESA	DESA	P-4	00-M-ESA-001122-I-NY
Sumitro, Wiryanto	M	UNJSPF	UNJSPF	P-4	00-F-JSP-001429-I-NY
Tabourian, Katia	F	DM/OCSS	DM/OCSS	P-4	00-A-DOM-001326-I-NY
Vaughan, Caroline	F	DM/OHRM	DM/OHRM	P-4	00-T-DOM-001482-I-NY
Vigie, Stephane[a]	M	DPKO	DPKO	P-4	00-A-DPK-001199-E-NY
Abdalla, Kathleen[a]	F	DESA	DESA	P-5	00-E-ESA-001087-E-NY
Brister, Judith	F	DESA	DESA	P-5	00-E-ESA-001127-E-NY
Charnsupharindr, Anchalee	F	DM/OHRM	ESCAP	P-5	00-A-ESC-00X136-E-BA
Crook, Gary	M	UNCTAD	UNCTAD	P-5	OO-E-TAD-400386-E-GE
Haegglund, Erik Olof	M	OCHA	OCHA	P-5	[b]
Hamdi, Mongi	M	UNCTAD	UNCTAD	P-5	00-E-TAD-400267-E-GE
Piazzi, Sergio	M	OCHA	OCHA	P-5	[b]
Saint-Roch, Latifa Amine	F	UNOG	UNOV	P-5	00-T-UNV-00X159-VI
Schweinfest, Stefan[a]	M	DESA	DESA	P-5	00-M-ESA-001020-E-NY
Placement					
Kim, Seok-Ran	F	ECA	DESA	P-3	00-S-ESA-001320-I-NY
Mortimore, Michael	M	ECLAC	UNCTAD	P-5	00-E-TAD-400324-E-GE

[a] The Secretary-General approved a list of alternate candidates proposed by the Department in accordance with the provisions outlined in administrative instruction ST/AI/1999/8. Should the selected candidate decline or fail to take up the functions for which he or she has been selected within two months, or vacate the post for any reason within six months of the Secretary-General's decision, another candidate from the short list may be selected by the Secretary-General on the recommendation of the head of the Department.

[b] The vacancy announcement was waived in accordance with the provisions of administrative instruction ST/AI/1999/8.

United Nations ST/IC/2001/29

Secretariat

17 April 2001

Information circular*

To: Members of the staff

From: The Assistant Secretary-General for Human Resources Management

Subject: **Placement and promotion list for staff in the General Service and related categories**

1. The purpose of the present information circular is to inform staff members of recommendations made by the Appointment and Promotion Panel that have been approved by the Secretary-General in respect of placements and promotions.

2. This list, which includes staff in the General Service and related categories, is issued monthly to enhance transparency within the Secretariat.

3. In order to ensure equitable treatment in promoting staff members, implementation will continue under the terms of administrative instruction ST/AI/1999/8 on placement and promotion, i.e., effective the first day of the month following approval by the Secretary-General, subject to the availability of the post and the assumption of the higher-level functions.

4. The attached list includes placements and promotions approved in March 2001.

* Expiration date of the present information circular: 31 December 2001.

01-33679 (E) 260401

Annex

Placement and promotion
1 to 31 March 2001

Name	*Gender*	*Releasing department/office*	*Receiving department/office*	*Post level*	*Vacancy number*
Promotion					
Dinand, Maud	F	OLA	DM/OHRM	G-5	00-G-HRM-1410-G5
Lay, Kyaw Kyaw	M	DPKO	DPKO	G-5	00-G-DPK-1510-G5
Odege, Kalu	M	DESA	DESA	G-5	00-G-ESA-989-G5
Pan, Gavin	M	UNMOVIC	UNMOVIC	G-5	00-G-VIC-1440-G5
Perera, Manel	F	DM/OPPBA	DM/OPPBA	G-5	*
Sall, Aly	M	DPI	DPI	G-5	00-G-DPI-1497-G5
Sotelo, Marilou	F	DGAACS	DGAACS	G-5	00-G-DGA-1193-G5
Tan, Hong	M	UNMOVIC	UNMOVIC	G-5	00-G-VIC-1436-G5
Valero, Anamaria	F	UNMOVIC	UNMOVIC	G-5	00-G-VIC-1428-G5
Zhagora, Vera	F	DPI	DPI	G-5	00-G-DPI-1420-G5
Garcia Cordon, Maria Del Sol	F	DESA	DESA	G-7	00-G-ESA-1330-G7

* The vacancy announcement was waived in accordance with the provisions of administrative instruction ST/AI/1999/8.

United Nations ST/IC/2001/30

Secretariat

20 April 2001

Information circular*

To: Members of the staff

From: The Assistant Secretary-General for Human Resources Management

Subject: **United Nations internship programme**

1. The purpose of the present circular is to inform staff members about the arrangements for the internship programme at Headquarters pursuant to ST/AI/2000/9.

I. Application procedure

Eligibility requirements

2. The Secretary-General may accept interns provided the following conditions are met:

(a) Applicants are enrolled in a degree programme in a graduate school (second university degree or higher) at the time of application and during the internship; or

(b) Applicants pursuing their studies in countries where higher education is not divided into undergraduate and graduate stages have completed at least four years of full-time studies towards the completion of a degree at a university or equivalent institution.

Internship periods

3. There are three internship periods each year: spring, mid-January to mid-March; summer, early June to early August; and fall, mid-September to mid-November.

Required documents

4. Graduate students who meet the eligibility requirements for an internship with the United Nations and who wish to be considered must submit the official United Nations internship application form (form P.135), which is annexed to the present

* Expiration date of the present information circular: 31 December 2003.

01-34547 (E) 080501

circular and is also available online at *www.un.org/Depts/OHRM/intern.htm*. Applicants must also submit a copy of their most recent resume or curriculum vitae and an essay setting out the reasons for which they are seeking an internship with the United Nations.

Submission of applications

5. Applications are to be forwarded to the Office of Human Resources Management, preferably by email (OHRM_interns@un.org), no earlier than 12 months and no later than 4 months prior to the desired internship period. Applications may also be faxed to (212) 963-3683 or mailed to the following address:

Internship Coordinator
Office of Human Resources Management
Room S-2590 D
United Nations
New York, New York 10017
United States of America

6. Applicants who are selected will be requested to sign the "Internship agreement for the United Nations", contained in the annex to ST/AI/2000/9, and to provide a medical certificate stating that they are in good health.

II. Working conditions

7. The terms of the internship programme are set out in sections 3, 4 and 5 of ST/AI/2000/9. The internship programme is normally on a full-time basis. Interns are expected to work five days a week in the department/office that has selected them, under the supervision of a staff member. During the internship session, interns will be provided with a desk, phone and computer access. Interns do not receive a salary or emoluments from the United Nations.

8. Supervisors are responsible for the content of the assignment of the intern, which should, where feasible, be explained fully to the intern prior to the commencement of the internship. Terms of reference describing the content of the tasks and responsibilities of the internship assignment should be prepared.

9. An orientation programme for all new interns will be offered by the Office of Human Resources Management at the beginning of each internship period. The Internship Coordinator will be available to assist supervisors and interns throughout the period, as needed.

III. Evaluation

10. At the end of the internship, the supervisor should prepare a written evaluation of the intern's performance and organize a meeting with him/her to provide constructive feedback.

UNITED NATIONS NATIONS UNIES

New York

Headquarters Internship Programme Application Form*

I. PERSONAL DATA			
1. Family name (surname):		2. First name (given name):	
3. Gender:	4. Date of birth (dd/mm/yy):	5. City/Country of birth:	6. Present nationality:
7. Nationality at birth:	8. Present address:		
9. Permanent address:			

II. EMERGENCY INFORMATION		
In case of emergency, please notify:		
10. Family name (surname):		11. First name (given name):
12. Relationship to applicant:	13. Address/Telephone:	

* Please type in English or French (a reference to a c.v. is not sufficient). Applications should be submitted by e-mail (ohrm_interns@un.org), if possible, or by mail or fax. Handwritten applications will not be accepted.

III. EDUCATION, EMPLOYMENT AND PERSONAL SKILLS INFORMATION

Higher Education (College/University):
Clearly state the title of the degree(s), the exact starting date and the date when the degree of the current program enrollment ("education to be completed") will be obtained. Proof of enrollment in a second university level program (for instance a Master's Degree programme) or higher education (for instance a Ph.D. programme) during the requested internship period may be required at a later stage in the selection process.

14. **Current Education:**

Institution Name, City, Country	Attended		Degrees obtained	Major subjects of study
	from (m/y)	to (m/y)		

15. **Completed Education:**

16. **Computer Skills:** ☐ Word-processing ☐ Internet research ☐ Spreadsheet ☐ Database ☐ Web page design ☐ Other:

17. **Publications (if any):**

18. **Knowledge of Languages:**

	Read		Write		Speak	
	Easily	Not easily	Easily	Not Easily	Easily	Not easily
Mother Tongue (please specify):	☐	☐	☐	☐	☐	☐
English:	☐	☐	☐	☐	☐	☐
French:	☐	☐	☐	☐	☐	☐
Other (please specify):	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

19. **Scholarships/Awards:**

20. **Career Plans:**

IV. INTERNSHIP INFORMATION

21. Preferred work assignment: Please indicate **by numbering** in the order of preference **three** main areas in which you would like to be considered for an internship:

_ Accounting & Auditing	_ Environmental Affairs	_ Public Information/Journalism
_ Administration & Management	_ Humanitarian Affairs	_ Social Research
_ Computer Systems	_ Law of the Sea	_ Statistics
_ Demography	_ Legal Affairs	_ Sustainable Development
_ Development Planning & Analysis	_ Library Science	_ Translation & Terminology
_ Disarmament Affairs	_ Peacekeeping Operations	_ Women's Issues
_ Economic Research	_ Political Affairs	

22. Please indicate in order of preference your availability for the internship period:

☐ Mid-January to mid-March ☐ Early June to early August ☐ Mid-September to mid -November

23. Other relevant information:

	Yes	No
a. Have you ever applied for regular employment with the United Nations?	☐	☐
b. Have you ever been arrested, indicted, or summoned into court as a defendant in a criminal proceeding, or convicted, fined or imprisoned for the violation of any law (excluding minor traffic violations)? If yes, please explain and attach the release document from the authorities.	☐	☐

24. I hereby certify that the foregoing statements and answers are true, complete and correct to the best of my knowledge and belief and can be verified at any time.

Signature: (when applying by e-mail, **type** your name)

_____ Date: (dd/mm/yy) _____

Before sending this application, please use the following checklist to verify whether you have followed all necessary steps:

1. All questions in the form have been answered.
2. A curriculum vitae and short written essay (150-250 words) stating your interest in obtaining the internship are attached to the application.
3. The form has been signed by the applicant (see #24 above).

N.B. When the application is submitted by e-mail, please submit all papers as attached documents (preferably in MS Word). Please use your family name followed by your birth date as the file name (example: Smith 15-12-1975). You may type your signature.

United Nations ST/IC/2001/31

Secretariat

20 April 2001

Information circular*

To: Members of the staff at Headquarters

From: The Assistant Secretary-General for Human Resources Management

Subject: **United Nations Staff Relief Committee for the Victims of the Earthquakes in El Salvador and India**

1. The disastrous earthquakes which recently hit El Salvador twice (13 January and 13 February 2001) and the western province of Gujarat in India (26 January 2001) have claimed the lives of thousands of people. A large number of them have been severely injured and rendered homeless. These disasters have affected the economy and fragile environment of these countries, worsening pre-existing conditions of vulnerability. According to estimates, the cost of immediate relief and rehabilitation in the two countries will run into hundreds of millions of dollars. The emergency and reconstruction needs exceed the capacity of national and local authorities.

2. International relief agencies have responded generously. However, in the wake of the disaster and its aftershocks, millions of people will continue to depend on outside aid for several months to come. With the approval of the Secretary-General, the Staff Committee has established the United Nations Staff Relief Committee for the Victims of the Earthquakes in El Salvador and India to appeal for funds to alleviate the suffering of the victims. The Committee is composed of Diana Guillen, Chairperson, Rajinder Kumar, Co-Chairperson, Sonia Burgos, Coordinator, and Christiane Leboeuf, Treasurer.

3. Many staff members have already sent donations in support of this cause through other relief organizations. This current appeal is being launched so that other staff members who have inquired about the humanitarian assistance drive can now contribute. Collections of contributions will take place on 30 April and 16 May 2001. An account has been established by the Treasurer of the Staff Committee at the United Nations Federal Credit Union, where staff can make direct deposits until 16 May 2001 to the United Nations Staff Relief Committee for the Victims of the Earthquakes in El Salvador and India, Account No. 170212.

* Expiration date of the present circular: 31 May 2001.

01-34229 (E) 260401

4. Contributions may also be made by cheque, payable to the "United Nations Staff Relief Committee for El Salvador and India" and addressed to the Treasurer, Christiane Leboeuf, Room S-0525.

5. Staff who are overseas and would like to contribute can do so by sending a wire transfer to the account number given above, using ABA# 226078609.

6. Contributions will be donated to the Office for the Coordination of Humanitarian Affairs for disbursement.

United Nations ST/IC/2001/32

Secretariat

4 May 2001

Information circular*

To: Members of the staff

From: The Assistant Secretary-General for Central Support Services

Subject: **Indoor air and drinking water quality tests and inspections of the Headquarters buildings**

1. The purpose of the present circular is to inform members of the staff that semi-annual indoor air and drinking water quality tests and inspections of the Headquarters complex are scheduled for 14 May through 31 May 2001. The work will be performed during normal office hours according to the following schedule:

Locations	*Dates*
Secretariat Building	14-15 May
General Assembly Building	16 May
Conference Building	17 May
Library Building	18 May
North Lawn Building	17-18 May
(Weekend)	
DC-1 Building	21 May
DC-2 Building	22 May
UNITAR Building	23 May
304 East 45th Street (FF Building)	23-24 May
Archives (FF and Falchi buildings)	24-25 May
(Weekend)	

* Expiration date of the present information circular: 15 June 2001.

01-36095 (E) 150501

Locations	*Dates*
Nigeria House	29-30 May
Alcoa Building	30-31 May
Drinking water testing	Mixed throughout – as time allows

2. For further information, please contact the Plant Engineering Section of the Facilities Management Division at extension 3-7851.

United Nations ST/IC/2001/33

Secretariat

11 May 2001

Information circular*

To: Members of delegations and staff

From: The Assistant Secretary-General for Central Support Services

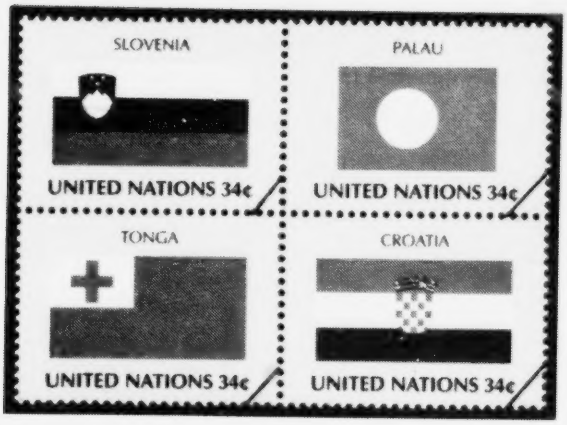
Subject: **First day of issue: 25 May 2001 — Flag series and definitive stamps and stationery**

Flag stamps

1. On Friday, 25 May 2001, the United Nations Postal Administration (UNPA) will continue with the stamps of the flag series by releasing eight new stamps illustrating the flags of an additional eight Member States of the United Nations. The two different sheets of sixteen stamps will accommodate four different flags, each in blocks of four. The denominations of the new stamps will be 34 cents. The countries are:

Sheet 47 — Slovenia, Palau, Tonga, Croatia

Sheet 48 — The former Yugoslav Republic of Macedonia, Kiribati, Andorra, Nauru

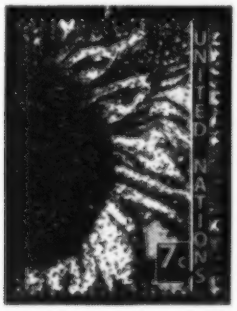


* Expiration date of the present information circular: 8 June 2001.

01-37064 (E) 170501

Definitive stamps and stationery

2. On 25 May 2001, two new definitive stamps in denominations of 7 and 34 cents will be issued to meet current and make-up postage rates. They are each printed in sheets of 20 stamps. The stamps were designed by Rorie Katz (United Nations).



3. On 25 May 2001, UNPA will issue a 34-cent pre-stamped envelope in both standard and large sizes to conform with current postage rates. A new 70-cent air letter and a 70-cent postal card will also be released on the same day.

General information

4. For the convenience of collectors, UNPA at Headquarters will provide prepared and cancelled New York, Geneva and Vienna first-day covers on the UNPA official first-day cachets **only**. Members of delegations and the staff can obtain these items on Friday, 25 May 2001, at the following locations:

(a) The UNPA sales counter in the concourse of the General Assembly Building: 9 a.m. to 5 p.m.;

(b) Counter at the north end of the Secretariat lobby from 9 a.m. to 4 p.m.

5. First-day-of-issue cancellations can be obtained at a temporary United States Postal Service substation located outside the United Nations Bookshop in the concourse of the General Assembly Building from 9 a.m. to 5 p.m.

6. Information on United Nations stamps can be accessed on the Internet at www.un.org/Depts/UNPA.

United Nations ST/IC/2001/34

Secretariat

14 May 2001

Information circular*

To: Members of the staff at Headquarters

From: The Assistant Secretary-General for Human Resources Management

Subject: **Language proficiency examinations, January and May 2002**

1. The purpose of the present circular is to advise staff members of the registration dates and schedules for the two sessions of the United Nations language proficiency examinations to be held in 2002 in the six official languages of the United Nations (Arabic, Chinese, English, French, Russian and Spanish) in order to confirm the written and spoken knowledge of the languages and to qualify for language-related incentives.

2. The 2002 language proficiency examinations and their respective registration dates are as follows:

First session	Tuesday and Wednesday, 29 and 30 January 2002
Registration, first session	Thursday, 17 January to Friday, 25 January 2002
Second session	Tuesday and Wednesday, 21 and 22 May 2002
Registration, second session	Thursday, 9 May to Friday, 17 May 2002

Those who wish to take the examination in January or May 2002 may register with the Staff Development and Learning Service in room S-606 (ext. 3-7056) between 1 and 3 p.m. on the above registration dates. The language proficiency examination form should be filled out for each language examination requested at the time of registration.

3. The language proficiency examinations consist of a written and an oral part. The schedules for the January and May 2002 written examinations are as follows:

* Expiration date of the present information circular: 31 December 2002.

01-37091 (E) 180501

(a) First session

Tuesday, 29 January 2002

English ..... 9 a.m. to 12.30 p.m.

Chinese ..... 2 p.m. to 5.30 p.m.

Russian ..... 2 p.m. to 5.30 p.m.

Wednesday, 30 January 2002

French ..... 9 a.m. to 12.30 p.m.

Arabic ..... 2 p.m. to 5.30 p.m.

Spanish ..... 2 p.m. to 5.30 p.m.

(b) Second session

Tuesday, 21 May 2002

English..... 9 a.m. to 12.30 p.m.

Chinese..... 2 p.m. to 5.30 p.m.

Russian..... 2 p.m. to 5.30 p.m.

Wednesday, 22 May 2002

French..... 9 a.m. to 12.30 p.m.

Arabic..... 2 p.m. to 5.30 p.m.

Spanish..... 2 p.m. to 5.30 p.m.

Candidates are advised to arrive 15 minutes before the start of the examination in order to allow for check-in procedures.

4. The conference room number where each written examination will be held will be posted on the bulletin boards in the Secretariat Building and in the DC1, DC2 and DC3 buildings. Candidates should check the bulletin boards, as individual notices are not sent for the written examinations.

5. The oral examination will consist of individual 15-minute interviews. Candidates will be given interview appointments at the time of their registration.

6. Copies of sample examinations can be obtained in room S-606.

7. Candidates will receive written notification of their examination results for the first session by the end of April 2002 and for the second session by the end of July 2002. No results will be available prior to official notice.

8. Staff members are requested to consult administrative instruction ST/AI/1999/2 of 13 May 1999 on language proficiency and language incentives for the general principles and the conditions governing language proficiency examinations, including eligibility and requirements for passing the examination.

United Nations ST/IC/2001/35

Secretariat

22 May 2001

Information circular*

To: Members of the staff at Headquarters

From: The Controller

Subject: **Renewal of the Headquarters medical and dental insurance plans effective 1 July 2001, and annual enrolment campaign, 4-8 June 2001**

General

1. The purpose of the present circular is to announce:

(a) Changes in the premium and contribution rates for the medical and dental plans offered at Headquarters (Aetna preferred provider organization (PPO), Empire Blue Cross preferred provider organization (PPO), HIP Health Plan of New York (HIP) and CIGNA dental preferred provider organization (PPO)), which will come into effect on 1 July 2001 (see chart on p. 2);

(b) Modifications in plan benefits are as follows. With effect from 1 July 2001, the Empire Blue Cross PPO and Aetna "Open Choice" PPO plans will cover oral contraceptives for the purpose of preventing pregnancy under the respective prescription drug programmes. The Aetna plan, in addition, will provide for an enhanced eye examination and optical lens benefit, from once every 24 months for each benefit to once every 12 months. The HIP plan also contains modest enhancements in the areas of vision care and dental services. All other benefits under the Headquarters health insurance plans remain essentially unchanged.

2. Annexes I to VIII to the present circular set out plan outlines and benefit summaries. They are listed in paragraph 14.

* Expiration date of the present information circular: 30 June 2002.

01-38177 (E) 300501

Headquarters medical and dental insurance schedule of monthly premiums[a] and contribution rates[b] (Effective 1 July 2001)

	Aetna Open Choice		*Empire Blue Cross PPO*		*HIP*		*CIGNA Dental with Medical Plan*		*CIGNA Dental alone*
Type of coverage	*2000 rates*	*2001 rates*	*2000 rates*	*2001 rates*	*2000 rates*	*2001 rates*	*2000 rates*	*2001 rates*	*2001 rates*
Staff member only									
Premium rate ($)	369.85	395.57	229.84	244.14	234.08	264.18	44.83	49.40	49.40
Contribution rate (per cent)	2.95	3.16	1.84	1.95	1.88	2.12	0.33	0.36	0.48
Staff member and one child									
Premium rate ($)	737.97	789.32	458.60	487.16	440.08	482.31	89.66	98.80	98.80
Contribution rate (per cent)	5.16	5.52	3.25	3.45	2.95	3.23	0.59	0.65	0.86
Staff member and spouse									
Premium rate ($)	737.97	789.32	458.60	487.16	440.08	482.31	89.66	98.80	98.80
Contribution rate (per cent)	5.16	5.52	3.25	3.45	2.95	3.23	0.59	0.65	0.86
Staff member and two or more eligible family members									
Premium rate ($)	923.43	987.68	665.84	707.31	649.12	767.91	144.77	159.54	159.54
Contribution rate (per cent)	5.76	6.16	4.17	4.43	3.95	4.53	0.89	0.98	1.48

[a] The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization. Staff members may determine their exact contribution by multiplying their "medical net" salary (see below) by the related percentage of salary.

[b] "Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable. Actual contributions are capped at 85 per cent of the corresponding premium.

Annual enrolment campaign

3. The annual enrolment campaign at Headquarters will be held from 4 to 8 June 2001 in the Insurance Service of the Office of Programme Planning, Budget and Accounts, room S-2765, between the hours of 10 a.m. and 5 p.m. **Staff members at Headquarters must come in person to the Insurance Service to complete the application form and other forms as necessary.** The staff of the Insurance Service will be available during the designated dates and hours to provide information and answer specific questions regarding the health plans being offered to staff. In addition, representatives of the insurance companies will be on hand on 4 and 5 June to provide information about the various insurance plans offered. The insurance company desks will be located in the staff activities area near the Secretariat cafeteria entrance.

4. Staff members are reminded that this will be the **only** opportunity until the month of June 2002 to enrol in the United Nations medical and dental insurance plans. This is also an opportunity to review current health insurance coverages within or outside the Organization and either enrol in one of the United Nations plans or apply for changes within these plans. Staff members who are satisfied with their coverage do not need to take any action at this time.

5. The medical and dental plans being offered during the June campaign and the pages on which plan outlines may be found are as follows:

(a) Empire Blue Cross PPO (p. 8);

(b) Aetna "Open Choice" Plan (p. 19);

(c) HIP Health Plan of New York (HIP) (p. 30);

(d) CIGNA Dental PPO Plan (CIGNA) (p. 33).

6. The effective date of insurance coverage for all campaign applications, whether for enrolment, change of plan or change of family coverage, will be 1 July 2001. A change in enrolment between the Aetna and Blue Cross plans will oblige the participant to meet the annual out-of-network deductible in the new plan.

Eligibility and enrolment rules and procedures

7. By Secretary-General's bulletins ST/SGB/1997/1 and ST/SGB/1997/2, dated 28 May 1997, the Secretary-General introduced a new system for the promulgation of administrative issuances and information circulars. A separate administrative instruction will be issued in due course which will set out the eligibility criteria and enrolment rules and procedures governing all United Nations contributory health insurance plans. However, until the new administrative instruction is issued, the eligibility criteria and enrolment rules pertaining to the Headquarters medical and dental health insurance plans as set out in annex VII to the present circular will remain in effect.

Cessation of coverage of staff member and/or family members

8. The Insurance Service should be notified immediately of changes in the staff member's family that result in a family member ceasing to be eligible, for example, a spouse upon divorce or a child marrying or taking up full-time employment. The Insurance Service has initiated a procedure by which covered children who reach the age of 25 will be automatically dropped from the staff member's coverage at the end of the year in which they reach the age of 25. Other than with respect to the children reaching 25, **the responsibility for initiating the resulting change in coverage (e.g., from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member**. Staff members who wish to discontinue their coverage, or that of an eligible family member under a United Nations plan for any other reason, may do so at any time, although this is strongly discouraged. Such terminations of coverage should be communicated to the Insurance Service directly, in writing. It is in the interest of staff members to notify the Insurance Service promptly whenever changes in coverage occur, in order to benefit from any reduction in premium contribution which may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change to the Insurance Service.

After-service health insurance

9. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, the applicant must be enrolled in a United Nations scheme at the time of separation from service. A minimum of five years of prior coverage in a United Nations health insurance scheme is necessary to qualify for unsubsidized after-service health insurance participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. It should also be noted that only family members enrolled with the after-service health insurance staff member at the time of separation are eligible for continued coverage under the programme. **Enrolment in the after-service health insurance programme is not automatic. Application for enrolment must be made within 31 days following the date of separation.** Full details on the eligibility requirements and administrative procedures relating to after-service health insurance coverage are set out in administrative instruction ST/AI/394, dated 19 May 1994.

Conversion privilege

10. Participants who cease employment with the United Nations and are not eligible for after-service benefits may arrange for medical coverage under an individual contract. This provision applies to all medical plans currently offered. The conversion privilege means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. In general, unless the separating staff member has had a history of poor health, exercising the conversion privilege will be more costly than acquiring new insurance coverage. **In addition, the conversion privilege does not mean that the same insurance premium rates or schedule of benefits in effect for the United Nations group policy will be offered in respect of individual insurance contracts.** It should be noted, moreover, that the conversion privilege may be exercised only for separating staff who continue to reside in the United States, as the insurers cannot write individual

policies for persons residing abroad. In all cases, the conversion privilege must be exercised **within 31 days of the date of separation**. Details concerning conversion to individual policies under Aetna and Empire Blue Cross may be obtained from the Insurance Service, room S-2765. Details concerning conversion to individual policies under the HIP Health Plan of New York should be obtained from HIP directly. **The CIGNA dental plan does not have a conversion option.**

Claims and benefit inquiries and disputes

11. Although the staff of the Insurance Service is available to assist staff members in administrative matters concerning participation in the various Headquarters insurance plans and problematic claims issues, claims questions should always be taken up in the first instance directly with the insurance company concerned. The addresses and relevant telephone numbers of the insurance companies are listed in annex VIII to the present circular.

12. Staff members are reminded that the plan descriptions set out in annexes I to IV constitute summaries of the benefits available under the respective plans. Every care has been taken to ensure that the plan summaries are as comprehensive as possible. A more detailed description of the benefits of each plan, including certain exclusions and limitations, is set out in a Summary Plan Description (SPD) booklet. The SPDs are in preparation for each carrier and will be distributed when available. In the event of a claim dispute with any of the insurance carriers or plan administrators concerned, the resolution of such dispute will be guided by the terms and conditions of the policy contract in question and the final decision will rest with the insurance carrier or plan administrator and not with the United Nations.

Headquarters health insurance plans: outlines and summaries of benefits

How plans are costed

13. The United Nations policies with Aetna, Empire Blue Cross and CIGNA are "experience-rated". This means that the premium cost each year of the Aetna, Empire Blue Cross and CIGNA dental plans is based on the level of claims incurred in the prior year and expected rates of utilization and medical cost inflation for the renewal period. In effect, the costs of these plans (claims incurred plus administrative expenses) are borne collectively by participants in these schemes. In a year following a period of heavy utilization, premium increases are likely to be relatively high. Conversely, if utilization in the prior year has been moderate, the premium increase in the subsequent year will be correspondingly moderate. The HIP plan is "community-rated". This means the premium scale is based on the combined experience of all employers participating in the plan and not just the United Nations, and is approved by the relevant state insurance authorities. It should be emphasized, particularly with respect to the three experience-rated plans, that prudent utilization by all participants concerned will have the effect of moderating premium costs for the benefit of all.

Plan outlines and benefit summaries

14. Outlines of the health insurance plans offered as well as summaries of benefits of each plan are set out in the following annexes:

		Page
I.	Empire Blue Cross PPO	8
II.	Aetna "Open Choice" Plan	19
III.	HIP Health Plan of New York (HIP)	30
IV.	CIGNA Dental PPO Plan	33

15. In addition, information regarding the World Access emergency facility for Aetna and Empire Blue Cross subscribers, participating Aetna and Empire Blue Cross pharmacies as well as insurance carrier addresses and telephone numbers are set out in the following annexes:

V.	World Access	38
VI.	Aetna and Empire Blue Cross Plans: participating pharmacies	39
VII.	Eligibility and enrolment rules and procedures	40
VIII.	Insurance carrier addresses and telephone numbers for claims and benefit inquiries	44

Finding providers through the Internet

16. As printed provider directories rapidly become outdated, and as there is limited space to store them, online provider directories should be used to search for health-care providers, physicians, participating hospitals, pharmacies, medical equipment suppliers and dentists. Please refer to the chart on page 7, which provides the Internet address for each carrier as well as related instructions. Subscribers may search by location and/or by name.

Finding PPO providers through the "Insurance" Intranet web site

17. As an alternative to searching for providers directly on the Internet, participants may also initiate a search from the Intranet web site of the Insurance Service. On the United Nations Intranet home page, click on "Insurance" under the "Quicklinks" drop-down menu and then click on the insurance company desired from the Insurance Service home page. Then follow the instructions set out on the following page.

Claim forms

18. Arrangements have been made with Empire Blue Cross, Aetna and CIGNA to provide claim forms online through the United Nations Intranet (claim forms cannot be accessed through the Internet). Claim forms for these three companies will be found through the Insurance Service home page.

Provider internet web sites

Online provider directories	Instructions
AETNA www.aetnaushc.com/docfind/index.html	1. Select a search category, such as Doctors or Vision One. 2. Select OpenChoice PPO from the HealthPlan Menu. 3. Provide the search criteria to be used. 4. Click on the Continue button to see the listing of providers. If there are matches for the criteria you selected, you will be presented with a summary list of results.
EMPIRE BLUE CROSS www.bcbs.com/healthtravel/finder.html	1. Enter zip code, or city and state or an area code of the provider's telephone number. 2. Select PPO® Network for the type of network search. Scroll down. 3. Select the type of Health Care Provider. Scroll down. 4. Select the type of Health Care Provider by specialty. 5. Click "submit" button.
CIGNA www.cigna.com/general/misc/docdir.html	1. Click on Dentists. 2. Select managed Care Plan with Open Access to dentists: CIGNA Dental PPO. 3. Click on the Continue Search button at the bottom of the page. 4. Enter the provider's zip code or city and state if preferred. 5. Select dentist type (i.e., Endodontics, General Dentistry, Orthodontics). 6. Click on the Continue Search button.

Annex I

Empire Blue Cross PPO

No current benefits under the Empire Blue Cross PPO plan are eliminated or changed. However, effective 1 July 2001, oral contraceptives can be obtained from retail pharmacies in addition to the mail order facility.

Plan outline

The Empire Blue Cross PPO plan provides in-network benefits, including an extensive network of participating providers covering most medical specialties, as well as out-of-network (non-network) benefits. A network of physicians covering New York City, the New York metropolitan area and nationally, participate in the Empire Blue Cross PPO plan and accept as payment a fee schedule arranged with Empire Blue Cross. When treatment is rendered by an in-network provider, the only charge to the participant is a small co-payment, mostly $10 (for certain services co-payments vary between $0 and $35). On the other hand, the participant may also be treated by a physician who is not a participating practitioner in the plan. **Medical services rendered by non-participating (out-of-network) providers, when covered, will be reimbursed at 80 per cent, subject to the deductible and 20 per cent co-insurance and subject to the providers' fees falling within reasonable and customary norms**. If a participating physician refers a patient to another provider who is non-participating, the deductible and 20 per cent co-insurance will apply in connection with reimbursement of the cost of the services rendered by the non-participating provider, including mental health providers. A number of diagnostic laboratories are participating providers under the Empire Blue Cross PPO plan. When laboratory tests are required, it is important that the physician be told to send the tests to a participating laboratory, if possible. If this is done, the cost of the test will be paid in full and will not be subject to the normal deductible and co-insurance.

Premiums

The premiums and related percentages of salary contribution are shown on page 2 of the present circular.

Benefits

The package of benefits under the Empire Blue Cross PPO plan is itemized in the plan summary (p. 11).

Deductible. The annual deductible is $200 per individual and $500 per family.

Co-insurance — annual out-of-pocket maximum. The individual maximum is $1,000 and the family maximum is $2,500.

Lifetime maximum. There is no lifetime maximum with respect to network-incurred expenses, but there is a $1,000,000 lifetime maximum with respect to non-network reimbursements.

Oral contraceptives. Effective 1 July 2001, the Empire Blue Cross PPO plan is being enhanced to include coverage under the prescription drug programme for oral contraceptives for the purpose of preventing pregnancy. In the past, oral

contraceptives were covered only if medically necessary. Like other prescriptions, the per-cycle cost at a network pharmacy will be 15% of the cost of the drug, but never more than $15. Oral contraceptives will also be available by mail order with a $10 co-pay for a three-cycle supply. This enhanced coverage applies to oral contraceptives only.

Services for which pre-certification is required

Pre-certification of hospital and other institutional services with the Medical Management Program (telephone: 1 (800) 982-8089) is required. The reason for this is constructive, as pre-certification ensures that (a) all expenses related to the hospitalization or treatment will be covered and (b) that a hospitalization case is medically monitored from the first day of admission so that if complications should arise, or if after-hospital care should be required, the case may be managed promptly and effectively.

When to call the Medical Management Program

- At least two weeks prior to any planned surgery or hospital admission. This applies to ambulatory surgery as well as in-patient surgery;
- Within 24 hours of an emergency hospital admission;
- Within the first three months of pregnancy and no more than one business day after the actual delivery;
- Prior to receiving home health care or home infusion therapy services (the network vendor must call medical management to pre-certify benefits);
- Prior to admission to a skilled nursing facility;
- Prior to receiving hospice care;
- Prior to receiving physical, occupational, speech or vision therapy;
- Prior to cardiac rehabilitation;
- Prior to renting or purchasing durable medical equipment, prosthetics or orthotics (the network vendor must call medical management to pre-certify);
- Prior to undergoing magnetic resonance imaging scans (MRIs).

With respect to mental health care and alcohol and substance abuse treatments, pre-approval must be sought from Magellan Behavioral Health (telephone: 1 (800) 626-3643).

Medical Management penalties

If you do not comply with the Medical Management requirement, your hospital/facility benefits may be reduced as follows (does not apply for providers outside the United States):

- In-patient hospital admissions, ambulatory surgery, cardiac rehabilitation and home health care, hospice care, occupational speech and vision therapy, physical therapy, MRIs, and skilled nursing facilities — 50 per cent up to $2,500 maximum per admission;
- Home infusion therapy and prosthetics, orthotics and durable medical equipment (vendor is penalized, member is held harmless).

Home health care

Home health care is covered at 100 per cent and is limited annually to 200 visits of up to 4 hours per visit. To be eligible for reimbursement, home health care must be prescribed by a physician and determined to be medically necessary. A written prescription or home health care treatment plan is required as well as any supporting documentation from the physician to facilitate Empire Blue Cross' review of a claim for the payment of benefits. It is also a requirement (subject to a monetary penalty) that proposed home health care services be submitted to the Blue Cross Medical Management Program for a predetermination of benefits payable prior to contracting with a nursing or home health care agency. Services provided at home need not follow a hospital confinement.

It is important to note that covered home health care services **exclude** all types of custodial care services. Custodial care services are categorized as personal care and comprise services designed to help a person perform activities of daily living, which include assistance with bathing, eating, dressing, toileting, continence and transferring. Such services are performed at home or in other facilities such as nursing homes, adult day care centres and assisted living facilities. Custodial care services may be of a short-term nature or provided on a long-term basis. Health insurance plans, including the Empire Blue Cross PPO plan, provide no coverage for custodial care.

Worldwide participating Blue Cross hospitals

Subscribers to Empire Blue Cross health insurance plans have the benefit of a network of hospitals in more than 40 countries worldwide which accept the Empire Blue Cross ID card and which bill Empire Blue Cross directly for any medical services rendered. A list of these hospitals may be obtained from the Insurance Service, room S-2765, from the Insurance Intranet web site (click on "Empire Blue Cross worldwide hospitals"), or from the Empire Blue Cross Internet web site.

EMPIRE BLUE CROSS PPO BENEFITS SUMMARY		
BENEFITS	**IN-NETWORK[a]**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE	$0	$200 Individual $500 Maximum for a Family
CO-INSURANCE	$0	20%
ANNUAL OUT-OF-POCKET MAXIMUM	$0	$1,000 Individual $2,500 Family in addition to annual deductible
LIFETIME MAXIMUM	Unlimited In-Network benefits Up to $1Million lifetime Out-of-Network benefits	
DEPENDENT CHILDREN	Covered to end of calendar year in which child reaches age 25	
HOSPITAL BENEFITS		
Inpatient[b] (except behavioural health) - Unlimited days – semiprivate room & board - Hospital-provided services - Routine nursery care	$0	Deductible and 20% co-insurance
Outpatient - Surgery and ambulatory surgery[b] - Pre-surgical testing (performed within 7 days of scheduled surgery) - Blood - Chemotherapy and radiation therapy - Mammography screening and cervical cancer screening	$0	Deductible and 20% co-insurance
Emergency Room/Facility[c] (initial visit) - Accidental injury - Sudden and serious medical condition	$35 co-payment (waived if admitted within 24 hours)	$35 co-payment (waived if admitted within 24 hours)
OTHER FACILITY BENEFITS		
Home Health Care[b,d] - Up to 200 visits per calendar year - Home Infusion Therapy	 $0 $0	- 20% co-insurance only (deductible does not apply) - Covered in-network only
Outpatient Kidney Dialysis Home, hospital based or free-standing facility treatment	$0	Deductible and 20% co-insurance
Skilled Nursing Facility[b] Up to 120 days per calendar year	$0	In-network only

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Hospice[b] Up to 210 days per lifetime	$0	In-network only
Physical Therapy[b] Up to 60 inpatient days per calendar year	$0	Deductible and 20% co-insurance
PREVENTIVE CARE BENEFITS		
Annual Physical Exam	$10 co-payment	In-network only
Diagnostic Screening Tests	$0	Deductible and 20% co-insurance
Prostate Specific Antigen (PSA) Test	$0	Deductible and 20% co-insurance
Well Woman Care	$10 co-payment	Deductible and 20% co-insurance
Mammography Screening	$0	Deductible and 20% co-insurance
Well Child Care **(including recommended immunizations)**[d] - Newborn Baby 1 in-hospital exam at birth - Birth to 1 year of age 6 visits - 1 through 2 years of age 3 visits - 3 through 6 years of age 4 visits - 7 up to 19th birthday 6 visits	$0	Deductible and 20% co-insurance
MEDICAL BENEFITS		
Office/Home Visits/Office Consultations	$10 co-payment	Deductible and 20% co-insurance
Surgery	$0	Deductible and 20% co-insurance
Surgical Assistant[c]	$0	Deductible and 20% co-insurance
Anaesthesia[f]	$0	Deductible and 20% co-insurance
Inpatient Visits/Consultations	$0	Deductible and 20% co-insurance
Maternity Care	$0	Deductible and 20% co-insurance
Diagnostic X-Rays	$0	Deductible and 20% co-insurance
Lab Tests	$0	Deductible and 20% co-insurance
Chemotherapy & Radiation Therapy Hospital outpatient or physician's office	$0	Deductible and 20% co-insurance
MRIs[b]	$0	Deductible and 20% co-insurance
Cardiac Rehabilitation[b]	$10 co-payment	Deductible and 20% co-insurance

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Second Surgical Opinion[g]	$10 co-payment	Deductible and 20% co-insurance
Second Medical Opinion for Cancer Diagnosis	$10 co-payment	Deductible and 20% co-insurance[h]
Allergy Testing and Allergy Treatment	$10 co-payment per office visit for testing $0 for testing fees and treatment visits	Deductible and 20% co-insurance
Prosthetic, Orthotics and Durable Medical Equipment[i]	$0	In-network only
Medical Supplies	$0	$0
PHYSICAL THERAPY and OTHER SKILLED THERAPIES		
Physical Therapy[h] - 60 inpatient visits, and - 60 visits combined in home, office or outpatient facility	$0 $10 co-payment	Deductible and 20% co-insurance In-network only
Occupational, Speech, Vision[h] 30 visits combined in home, office or outpatient facility	$10 co-payment	In-network only
BEHAVIORAL HEALTH CARE BENEFITS		
Mental Health Care[d,j] - Up to 90 inpatient days per calendar year - Up to 60 outpatient visits in office or facility - Up to 90 professional visits per calendar year while in an inpatient facility	$0 $25 co-payment per visit $0	Deductible and 20% co-insurance
Outpatient Alcohol and Substance Abuse[d,j] Up to 60 outpatient visits which include 20 family counselling visits per calendar year	$0	Deductible and 20% co-insurance
Inpatient Alcohol and Substance Abuse[d,j] Up to 7 days detoxification and 30 days rehabilitation per calendar year	$0	Deductible and 20% co-insurance
OTHER BENEFITS		
Acupuncture	$10 co-payment	Deductible and 20% co-insurance
Chiropractic Care	$10 co-payment	Deductible and 20% co-insurance
Hearing Exam (every 3 years) **Hearing Appliance**	$10 co-payment Not covered	Deductible and 20% co-insurance Not covered
Ambulance[k]	$0 up to the allowed amount	

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs (Card and Mail Order Programme)	- 15% co-payment up to a maximum of $15 per prescription - $10 co-payment for mail order	*Within U.S.*: 40% co-insurance after deductible *Outside U.S.*: 20% co-insurance after deductible (claim form must be filed for reimbursement)
Vision Care Programme (in-network only through a designated group of providers)	- $5 co-payment for 1 exam every 24 months - $10 co-payment for basic frames - $35 co-payment for non-plan eyewear allowance	In-network only

[a] In-network services (except Mental Health or Alcohol/Substance Abuse) are those from a provider that participates with Empire or another BlueCross BlueShield Plan through the BlueCard Program, or a participating provider with another BlueCross BlueShield Plan that does not have a PPO network and does accept a negotiated rate arrangement as payment-in-full.

[b] Medical Management Programme must pre-approve or benefits will be reduced 50% up to $2,500.

[c] If admitted, Medical Management must be called within 24 hours or as soon as reasonably possible.

[d] Combined maximum visits for in-network and out-of-network services.

[e] If the surgical assistant is an out-of-network provider and is assisting a participating surgeon, payment will be made in full.

[f] If the anaesthesiologist is an out-of-network provider but is affiliated with a participating hospital, payment will be made in full.

[g] Charges to member do not apply if the second surgical opinion is arranged through the Medical Management Programme.

[h] If arranged through the Medical Management Programme, services provided by an out-of-network specialist will be covered as if the services had been in-network (i.e., subject to the in-network co-payment).

[i] In-network vendor must call Medical Management to pre-certify.

[j] Magellan Behavioral Health must pre-approve or benefits will be reduced 50% up to $2,500. Out-of-network mental health care does not require pre-certification; however, out-patient alcohol and substance abuse visits must be pre-certified. In-network mental health services are those from providers that participate with Magellan Behavioral Health.

[k] Air Ambulance and Ambulette services are not covered.

Discount prescription drug programme (Empire Pharmacy Management)

The Blue Cross Empire Pharmacy Management (EPM) discount prescription drug programme is administered by AdvanceRX. The Empire Pharmacy Management (EPM) programme reimburses at significant savings prescription drugs obtained from participating pharmacies. Under this programme, a retail pharmacy network as well as a mail order facility are provided by Empire Pharmacy Management through AdvanceRX.

Significant cost savings are being passed on to participants by utilizing either a participating pharmacy or the mail order facility. In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a brand-name drug be dispensed by indicating "Dispense as written" or "DAW", a generic equivalent drug will be provided by the pharmacist, and the discount off the AWP will average 43 per cent depending on the generic equivalent supplied. The discount for maintenance drugs obtained through AdvanceRX will range from 18 per cent to as high as 50 per cent off AWP, depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

The procedure under which prescription drugs are reimbursed through the Empire Pharmacy Management programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice **along with the Empire Blue Cross PPO card** (please refer to annex VI). The pharmacist will fill the prescription for up to a 34-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) on the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through the AdvanceRX mail order facility, which will charge a fixed $10 co-payment per prescription. The AdvanceRX claim form supplied with the Empire Blue Cross PPO card should be utilized for ordering maintenance drugs by mail. A new order form will be sent along with the filled prescription. The address and telephone number of the mail order prescription drug facility is as follows:

AdvanceRX
P.O. Box 660783
Dallas, TX 75266-0783

Tel. No. (888) 266-5691

It should be noted that if a generic equivalent is available and a participant receives a brand-name drug at his or her request, even though the physician has not specified a brand name by indicating "Dispense as written" (DAW) on the prescription, the participating pharmacy and/or the AdvanceRX mail order facility will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

As the prescription drug programme is administered separately by Empire Pharmacy Management, the annual deductible under the Empire Blue Cross PPO plan will **not** be applied to prescription drugs. At the same time, the prescription drug co-payment will also **not** count towards meeting the annual co-insurance limit of $1,000. Prescription drugs obtained outside the United States or within the United States but not through the Empire Pharmacy Management AdvanceRX participating network will be reimbursed through the submission of a claim form to the claims office at the following address:

Empire BCBS (EPM)
Pharmacy Unit
P.O. Box 5099
Middletown, NY 10940-9099

Tel. No. (800) 839-8442

The special claim form to be utilized for this purpose is available in the offices of the Insurance Service, room S-2765. **Claims submitted to the prescription drug claims office will be subject to the annual deductible**. Claims for prescription drugs dispensed outside the United States will be reimbursed at 80 per cent after deductible, while claims for prescription drugs dispensed within the United States but **not** through the Empire Pharmacy Management programme will be reimbursed at the rate of 60 per cent. In addition, the 20 or 40 per cent co-insurance will **not** count towards meeting the annual co-insurance limit of $1,000.

Behavioural health and substance abuse benefits

In-patient care for both the treatment of mental and nervous conditions and substance abuse as well as in-network out-patient treatment by a psychiatrist, clinical psychologist or psychiatric social worker requires prior approval by Behavioral Health Care Management (1-800-626-3643).

Vision care

To qualify for vision care benefits, you must receive care from a provider participating in the Empire Blue Cross PPO Davis Vision Network. There are no out-of-network benefits for vision care. To find a participating Davis Vision Network provider in your area, simply call 1-888-EYEBLUE (1-888-393-2583) between 9 a.m. and 5 p.m. weekdays, **or visit their web site at www.davisvision.com**.

The vision care benefits include an eye exam and eyewear, consisting of a select group of frames, and soft contact lenses once every 24 months. During this benefit period, you are **not** required to purchase the eyewear at the time of the examination, nor are you required to purchase the covered eyewear from the same provider who rendered the eye examination.

Service	*Amount you pay*
Eye exam	$5.00
Frames (limited selection)	$10.00
Premier frames	$40.00
Soft contact lenses — per pair (standard daily wear)	$25.00
Single vision lenses	0
Bifocal lenses	0
Trifocal lenses	0
Progressive addition lenses	$80.00
Blended segment lenses	$20.00
Photochromic single vision lenses	$15.00
Photochromic multifocal vision lenses	$25.00
Supershield single vision lenses	$15.00
Supershield multifocal lenses	$25.00
Ultraviolet coating	$10.00
Reflection-free coating	$33.00
Polaroid lenses	$60.00
Polycarbonate lenses	$30.00
High index lenses	$55.00
Transition lenses	$70.00

In addition, vision care benefits include a $35.00 allowance for non-plan frames.

Exclusions and other provisions

Certain expenses are not covered under the Empire Blue Cross PPO plan. These comprise expenses for services or supplies not deemed by Empire Blue Cross as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. In addition, inoculations for travel purposes are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Empire Blue Cross as reimbursable under the plan, Empire Blue Cross should be contacted at (800) 342-9816 prior to commencement of treatment. In addition, the Empire Blue Cross policy contract document is on file in the offices of the Insurance Service and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

Recourse if a claim is denied

If Empire Blue Cross denies a claim in whole or in part, the subscriber has the right to appeal the decision. Empire Blue Cross will send written notice of the reason for the denial. The subscriber then has 60 days to submit a written request for review. Empire Blue Cross will send a written decision with an explanation within 60 days of receiving the appeal. If special circumstances require more time, Empire Blue Cross can extend the review period up to 120 days from the date the appeal was received. For a review of a hospital or medical claim, write to:

Empire Blue Cross Blue Shield
PPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Time limit for filing a claim

Subscribers should note that claims for reimbursement must be submitted to Empire Blue Cross no later than two years from the date on which the medical expense was incurred. **Claims received by Empire Blue Cross later than two years after the date on which the expense was incurred will not be eligible for reimbursement.**

Empire's Internet Site

Subscribers in the Empire Blue Cross PPO plan are encouraged to activate an account on Empire Blue Cross's web site which permits participants to more effectively manage their coverage. The site is called **Empireblue.com** and can be accessed directly at www.empireblue.com.

Empireblue.com allows you to access the following services 24 hours a day, 7 days a week:

- Check and resolve claims
- Change your phone number
- Request ID cards
- Research and choose doctors
- Print an explanation of benefits
- Update your address*

* If you update your address on the Empire Blue Cross site, please also update your address change on the United Nations Intranet site so that the change becomes permanent in both systems.

To register on the Empire Blue Cross site:

- Click on "Register" in the Member Services window
- Enter your name, member ID number and date of birth
- Create your own personal password and login ID
- Request, and then enter your personal activation key

If you have any problems registering, please call Empire Blue Cross at 1-877-603-0923. Each member of your household over the age of 18 must register separately, and members under 18 can access their information through their parents' or guardians' personal home page.

Annex II

Aetna "Open Choice" Plan

Plan outline

The Aetna "Open Choice" health benefits plan (Aetna) offers worldwide coverage for hospitalization and surgical, medical and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing, whether an in-network or non-network provider.

Aetna "Open Choice" is a dual-track plan that offers all the benefits of the traditional Aetna indemnity plan, plus the option of a preferred provider organization (PPO) network of physicians and other medical providers nationwide. This means that participants can choose, if they wish, to go to a doctor who is in-network and pay only $10 per visit or treatment without any further need to file a claim with Aetna. Alternatively, **participants may opt to receive treatment from any physician not in the network and be reimbursed by Aetna in the usual way, subject to the annual deductible and the normal co-insurance and subject to the providers' fees falling within reasonable and customary norms**. A summary of the plan, both the in-network and the non-network (traditional indemnity) benefits, is set out in outline form commencing on page 21.

Under the non-network (traditional) track of the Aetna plan, when a participant has met the annual deductible of $125 per individual and $375 per family and a further $1,000 per covered individual in co-insurance (20 per cent of $5,000 of recognized expenses), Aetna will reimburse all further claims incurred in the year, subject to the provision that they be "reasonable and customary", at 100 per cent. The deductible and co-insurance requirement must be met each calendar year. There is no lifetime reimbursement limit under the Aetna plan. When a participant is treated by a network physician, paying the fixed $10 co-payment for each visit, it is important to note that those $10 amounts do not count towards meeting the $1,000 out-of-pocket expense limit referred to above. This is so because, under the in-network track of the plan, medical expenses are already considered to have been paid at 100 per cent to the network provider after the participant has met the fixed $10 co-pay.

Premium

The premiums and related percentages of salary contribution are shown on page 2 of the present circular.

Benefits

The package of benefits under the Aetna "Open Choice" plan is itemized in the plan summary (pp. 21-24).

With effect from 1 July 2001, the eye examination and optical lens benefit is improved. Instead of these benefits being available once every 24 months, the two benefits will henceforth be available every 12 months.

With effect from 1 July 2001, the Aetna "Open Choice" plan is being enhanced to include coverage under the prescription drug programme for oral contraceptives

for the purpose of preventing pregnancy. In the past, oral contraceptives were covered only if medically necessary. Like other prescriptions, the per-cycle cost at a network pharmacy will be 15 per cent of the cost of the drug, but never more than $15. Oral contraceptives will also be available by mail order with a $10 co-pay for a three-cycle supply. This enhanced coverage applies to oral contraceptives only.

Participants are reminded of the following particular provisions in the plan:

Private duty nursing and home health care. Private duty nursing is covered on an in-home basis only (no in-hospital benefit). In addition, the benefit is limited to $5,000 per year, with a $10,000 lifetime maximum. Home health care is covered at 100 per cent and is limited annually to 200 visits of up to 4 hours per visit. To be eligible for reimbursement, both private duty nursing and home health care services must be prescribed by a physician and determined to be medically necessary. A written prescription or home health care treatment plan is required as well as any supporting documentation from the physician to facilitate Aetna's review of a claim for the payment of benefits. It is strongly recommended that both in-home private duty nursing and home health care requirements be submitted to Aetna for a predetermination of benefits payable prior to contracting with a nursing or home health care agency. Services provided at home need not follow a hospital confinement.

It is important to note that covered home health care services exclude all types of custodial care services. Custodial care services are categorized as personal care and comprise services designed to help a person perform activities of daily living, which include assistance with bathing, eating, dressing, toileting, continence and transferring. Such services are performed at home or in other facilities such as nursing homes, adult day-care centres and assisted living facilities. Custodial care services may be of a short-term nature or provided on a long-term basis. Health insurance plans, including the Aetna plan, provide no coverage for custodial care.

Pre-registration of hospital and other institutional services. Mandatory pre-registration applies to in-hospital admissions, skilled nursing facility admissions, home health care, private duty nursing and hospice care. The reason for such pre-registration (to which no financial penalty attaches) is a constructive one, namely that pre-registration assures the patient (a) that all related hospital expenses will be covered under the plan, and most importantly that (b) a hospitalization case is medically monitored from the first day of admission, so that if complications should arise, or if after-hospital care should be required, the case may be managed promptly and effectively. The telephone number to call for pre-registration of hospital admissions and the other services is: 1-800-333-4432. For an emergency admission, call within 48 hours, or the next business day if admitted on a weekend.

Artificial insemination. This benefit is subject to a maximum of six courses of treatment in a covered person's lifetime.

Non-network prescription drug reimbursement. Participants are reminded that non-network prescription drugs will be reimbursed at the rate of 60 per cent (40 per cent co-insurance), after deductible. In addition, the 40 per cent co-insurance which is the responsibility of the participant will **not** count towards meeting the annual out-of-pocket limit of $1,000. All prescriptions filled at pharmacies outside the United States will be reimbursed at 80 per cent after deductible. However, the co-insurance will not count towards fulfilment of the annual $1,000 out-of-pocket limit.

AETNA OPEN CHOICE SUMMARY OF BENEFITS		
BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE Individual Family	 $0 $0	 $125 $375
CO-INSURANCE (% at which the plan pays benefits)	100% except where noted	100% Hospital; 80% all other, except where noted
OUT-OF-POCKET LIMIT Individual Family	N/A	 $1,000 $3,000 (network and prescription drug co-pays do not count towards the out-of-pocket limit)
LIFETIME MAXIMUM	Unlimited	Unlimited
CLAIM SUBMISSION	**PROVIDER** files claims	**YOU** file claims
HOSPITAL SERVICES AND RELATED CARE		
COVERAGE In-patient coverage Out-patient coverage	 100% 100%	
MANDATORY PRE-REGISTRATION **(1-800-333-4432)** Applies to in-patient hospital, skilled nursing facility, home health care, hospice care, and private duty nursing care	**Provider responsible**	**Subscriber or provider responsible**
(For emergency admission, call within 48 hours or next business day if admitted on weekend)		
Hospital Emergency Room Based on symptoms, i.e. constituting a perceived life threatening situation	100% including physician's charges after $35 co-pay (waived if admitted within 24 hours)	100% including physician's charges after $35 co-pay (waived if admitted within 24 hours)
Hospital Emergency Room For non-emergency care (examples of conditions: skin rash, ear ache, bronchitis, etc.)	80%	80% after deductible
Ambulance ***[There are no network providers for these services at the present time.]***	100%	
Skilled Nursing Facility 365 days per year	100%	
Private Duty Nursing (in-home only)	100% subject to a $5,000 maximum per year and $10,000 lifetime	
Home Health Care Up to 200 visits per year	100% Must be medically necessary and supported by a doctor's prescription medical report. Pre-certification is strongly recommended.	

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Hospice (210 days) Plus 5 days bereavement counselling	100%	
PHYSICIAN SERVICES **(excluding mental health and substance abuse treatment)**		
Office Visits For treatment of illness or injury (non-surgical)	100% after $10 co-pay	80% after deductible
Maternity (includes voluntary sterilization and voluntary abortion, see Family Planning)	100% after $10 co-pay	80% after deductible
Physician In-Hospital Services	100%	80% after deductible
Other In-Hospital Physician Services (e.g. attending independent physician who does not bill through hospital)	100%	80% after deductible
Surgery (in hospital or office)	100%	80% after deductible
Second Surgical Opinion	100% after $10 co-pay	100% after deductible
Anaesthesia	100% (if participating hospital)	80% after deductible
Allergy Testing and Treatment (given by a physician)	100% after $10 co-pay	80% after deductible
Allergy Injections (not given by a physician)	100%	80% after deductible
PREVENTIVE CARE		
Routine Physicals and Immunizations - Children age 19+ and adults: one routine exam every 24 months - Age 65+: one routine exam every 12 months	100% after $10 co-pay	80% after deductible
Well-child Care and Immunizations Well-child care to age 7: - 6 visits per year age 0 to 1 year - 2 visits per year age 1 to 2 years - 1 visit per year age 2 to 7 years One visit every 24 months from age 7 to 19	100%	
Routine Ob/Gyn Exam One routine exam per calendar year including one Pap smear	100% after $10 co-pay	80% after deductible
Family Planning - Office visits including tests and counselling - Surgical Sterilization procedures for vasectomy/tubal ligation (excludes reversals)	100% after $10 co-pay 100%	80% after deductible 80% after deductible

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment - Office visits including testing and counselling - Limited to procedures for correction of infertility including artificial insemination (but excluding in-vitro fertilization, G.I.F.T., Z.I.F.T., etc.)	100% after $10 co-pay 100%	80% after deductible 80% after deductible
Routine Mammogram (no age limit)	100%	80% after deductible 100% if performed on an in-patient basis or in the out-patient department of a hospital
Annual Urological exam by Urologist	100%	80% after deductible
MENTAL HEALTH AND ALCOHOL/DRUG ABUSE SERVICES		
MENTAL HEALTH IN-PATIENT SERVICES (1-800-424-1601) **In-patient Coverage** *[The benefit maximum is for network and non-network services combined.]*	100% Maximum benefit of 90 days per calendar year	100% after deductible Maximum benefit of 90 days per calendar year
These services are provided under the Focused Psychiatric Review (FPR) programme. Pre-registration of in-patient confinements is required. For in-network services, the network provider is responsible for pre-registration. For non-network in-patient services, either the physician or the participant must pre-register the confinement.		
Out-patient Coverage *[The benefit maximum is for network and non-network services combined.]*	100% Up to 50 visits per calendar year	80% after deductible Up to 50 visits per calendar year
Crisis Intervention	100% Up to 3 visits per calendar year	80% after deductible Up to 3 visits per calendar year
ALCOHOL/DRUG ABUSE **In-patient Coverage** *[The benefit maximum is for network and non-network services combined.]*	100% Up to 60 days per calendar year *2 confinements per lifetime*	100% after deductible Up to 60 days per calendar year
Out-patient Coverage *[The benefit maximum is for network and non-network services combined.]*	100% Up to 60 visits per calendar year	80% after deductible Up to 60 visits per calendar year
PRESCRIPTION DRUG BENEFITS		
Retail Programme (1-888-792-8742) **(30-day supply)**	15% co-pay up to a maximum of $15 per prescription	*Within U.S.* 60% after deductible *Outside U.S.* 80% after deductible The co-payment will not count towards $1,000/$3,000 out-of-pocket limit
Mail Order Programme (1-877-849-5521) **(90-day supply)**	100% after $10 co-pay for up to a 90-day supply from participating mail order vendor	
Prescriptions for both Retail Programme and Mail Order Programme — when brand name is requested, you pay the co-pay plus the difference between the brand and generic price, unless the physician specifically prescribes the brand-name drug.		

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
VISION AND HEARING CARE		
Eye Exam (once every 12 months)	100% after $10 co-pay	80% after deductible
Optical Lenses (including contact lenses once every 12 months)	80%, deductible does not apply; $100 maximum for any two lenses and frames purchased in a 12-month period	
Vision One Programme (1-800-793-8616)	Save up to 65% on frames, up to 50% on lenses, and about 20% on contact lenses at participating Cole Vision Centers	
Hearing Exam Evaluation and Audiometric exam	100% after $10 co-pay (one exam every three years; exam must be performed by otolaryngologist or state certified audiologist)	80% after deductible (one exam every three years; exam must be performed by otolaryngologist or state certified audiologist)
Hearing Device ***[There are no network providers for these services at the present time.]***	80%, deductible does not apply; $750 maximum benefit, one hearing aid per ear every three years	
OTHER HEALTH CARE		
Short-term Rehabilitation Physical and Occupational Therapy	100%	80% after deductible
Laboratory Tests, Diagnostic X-Rays	100%	80% after deductible
Speech Therapy	80%, deductible does not apply (where services are rendered by a participating provider, 100% reimbursement applies after $10 co-pay)	
Out-patient Diabetic Self-Management Education Programme	80%, deductible does not apply *[If services are rendered in a hospital, 100% reimbursement applies with no co-pay. If rendered in a network doctor's office, 100% reimbursement with $10 co-pay applies]*	
Durable Medical Equipment	80%, deductible does not apply *[If services are rendered by a network provider or within a hospital setting, 100% reimbursement applies with no co-pay]*	
Acupuncture (for chronic pain treatment only; services must be rendered by a medical doctor or licensed acupuncturist)	100% after $10 co-pay up to a maximum benefit of $1,000/year	80% after deductible up to a maximum benefit of $1,000/year *[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]*
Chiropractic Care	100% after $10 co-pay up to a maximum benefit of $1,000/year	80% after deductible up to a maximum benefit of $1,000/year *[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]*

Eye examination

An eye examination once every 12 months is covered at 100 per cent after a $10 co-payment if carried out by a network provider, and at 80 per cent after deductible if carried out by an out-of-network provider.

"Vision One" eyecare discount programme

The Vision One programme offers subscribers and covered family members immediate discounts on eyecare needs, including frames, lenses and contact lenses. This programme is an addition to, not a substitute for, the existing optical lens benefit which will be continued as before. The programme is available at over 2,500 locations nationwide, including the optical centres in national retail outlets, such as Sears, JC Penney and Montgomery Ward and many of the Pearle Vision Centers, as well as selected independent providers/offices. To obtain the discounts available under this programme, it is only necessary to show the provider the Aetna identification card at the time of the visit. The provider will apply the discounts to any purchases made and will accept valid prescriptions from any licensed optometrist or ophthalmologist. The Vision One programme may be used as often as desired. As it is simply a discount programme, claim forms are not required. For more details and outlet locations, call Vision One at (800) 793-8616, weekdays from 9 a.m. to 9 p.m. and Saturdays from 9 a.m. to 5 p.m. Vision One providers can also be found on the Internet at http://www.aetnaushc.com/docfind/index.html and click on "Vision One Providers". A schedule of costs and typical savings is set out below.

Benefits	*Vision One cost*
Frames	
Priced up to $60.00 retail	$16.00
Priced from $61.00 to $80.00 retail	$26.00
Priced from $81.00 to $100.00 retail	$36.00
Priced from $101.00 to $200.00 retail	50 per cent
Lenses — per pair (uncoated plastic)	
Single vision	$28.00
Bifocal	$48.00
Trifocal	$58.00
Lenticular	$98.00
Lens options — per pair (add to lens prices above)	
Standard-Progressive (no-line bifocals)	$50.00
Polycarbonate	$30.00
Scratch-resistant coating	$12.00
Ultraviolet coating	$12.00
Solid or gradient tint	$8.00
Glass	$18.00
Photochromic	$34.00
Anti-reflective coating	$35.00

Eye examinations (by licensed independent doctors of optometry)

Eyeglasses — $34.00

Contact lenses — $10.00 off normal fee

Contact lenses (two ways to save on contact lenses)

1. Visit the more than 2,500 locations nationwide and save 20 per cent discount from regular retail prices.
2. Use the Vision One Contact Lens Replacement Program for additional savings and convenience.

   Call (800) 391-5367 for this service.

Dispensing fee

The fee for fitting and dispensing (including unlimited eyeglass adjustments) is only $10.00.

Acupuncture benefits

The Aetna "Open Choice" plan provides benefits for acupuncture treatment rendered by a medical doctor or licensed acupuncturist, up to a maximum benefit of $1,000 per calendar year. The scope of the benefit may be summarized as follows:

Covered diagnoses for treatment by acupuncture include the following types of chronic pain syndrome:

- Tension headache
- Migraine headache
- Psychalgia
- Neuralgia
- Backache
- Lumbago
- Muscle spasm
- Bursitis

Acupuncture treatment in lieu of anaesthesia has been recognized as a reimbursable procedure by Aetna under the traditional plan. This benefit, as well as all other benefits under the traditional plan, will be maintained under Aetna "Open Choice".

Mental and nervous and substance abuse benefits

A. In-patient benefits

All hospitalization for mental and nervous and substance abuse conditions is subject to the Focused Psychiatric Review (FPR) procedure. **Staff members are assured that the FPR programme is conducted in the strictest confidence.** The procedure is as follows:

Prior to a non-emergency hospital admission, Aetna must be informed of the intended admission. This is accomplished by placing a telephone call to a toll-free Aetna number (800-424-1601). The call will be taken by a member of the Aetna FPR team. The telephone call may be placed by the subscriber

himself or herself, the attending physician, a family member, or any other person acting for the patient to be hospitalized.

The initial information required by Aetna in order to pre-certify the admission includes the subscriber's identification number (payroll index number), the reason for the admission, the physician's name, address and telephone number, the hospital name, address and telephone number, and the scheduled admission date.

The FPR specialist then contacts the attending physician to review the information prior to certification of the admission. If the attending physician makes the original call to the 800 number, this step will be accomplished at that time. The FPR specialist certifies a certain number of in-patient days, if appropriate, and develops a plan of regular follow-up visits with the attending physician.

An emergency admission, which cannot be pre-certified before the confinement begins, must be called in to the Aetna FPR number within 48 hours of the emergency admission.

B. In-patient mental and nervous and substance abuse care

The full cost (semi-private accommodation) of 30 days of hospitalization for the treatment of mental and nervous disorders. Hospital confinements beyond 30 days are reimbursed subject to the normal deductible and co-insurance provisions.

The full cost (semi-private accommodation) of 30 days of hospitalization for substance (alcohol and/or drug) abuse detoxification and rehabilitation, limited to two 30-day benefit periods in a lifetime. Continuous confinement of up to 30 days beyond this 30-day limit is subject to the provision under the paragraph below.

Coverage for up to 30 days of hospitalization for substance abuse (alcohol and/or drug) rehabilitation after the 30-day hospitalization benefit described in the paragraph above has been exhausted. This benefit is available twice in a lifetime and is applicable only as a continuation of each of the two 30-day hospitalization periods provided under the preceding paragraph.

C. Out-patient mental and nervous and substance abuse care

A maximum of 50 out-patient visits per year to a medical doctor engaged in the practice of psychiatry (and, depending on the state in which the provider is licensed, for the services of a psychologist and psychiatric social worker). If treatment is obtained from a network provider, the plan pays 100 per cent of the cost. If the provider does not participate in the PPO network, reimbursement will be at 80 per cent of the reasonable and customary fee level for the area in which the services are rendered, and will be subject to the annual deductible. The 50-visit annual maximum is for network and non-network treatment combined. Co-insurance payments made in respect of out-of-network treatment will not be applied to the $1,000 annual co-insurance maximum.

Sixty out-patient visits per calendar year for the treatment of alcoholism or drug abuse diagnosed by a physician. Of these 60 annual visits, 20 may be utilized for the counselling of the patient's family if directly related to the patient's alcoholism or drug abuse.

Discount prescription drug programme (Aetna Pharmacy Management)

As announced in ST/IC/2000/38, with effect from 1 July 2000, Express Scripts Inc. (ESI) mail service programme replaced Walgreens Healthcare Plus as Aetna's contracted mail order pharmacy administrator. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through ESI which will charge a fixed $10 co-payment. ESI order forms are available at the Insurance Service office, room S-2765.

The Aetna Pharmacy Management (APM) prescription drug programme, along with its mail order affiliate, Express Scripts Inc. (ESI), reimburses, at significant savings, the cost of prescription drugs obtained from participating pharmacies and from the Express Scripts Inc. (ESI) mail order facility.

In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a specific brand be dispensed by indicating "Dispense as written" or "DAW", the generic equivalent drug will be provided by the pharmacist, and the discount off the AWP can be as high as 50 per cent, depending on the generic equivalent supplied. The discount for maintenance drugs obtained by mail through the Express Scripts Inc. (ESI) mail order facility will range from 18 per cent to as high as 50 per cent off AWP depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

The procedure under which prescription drugs are reimbursed through the Aetna Pharmacy Management Programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice **along with the Aetna card** (please refer to annex VI). The pharmacist will fill the prescription for up to a 30-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) based upon the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

It should be noted that if a participant wishes to receive the brand-name drug even though the physician has not specifically prescribed the brand name, the participating pharmacy will charge a participant 15 per cent of the cost of the brand-name drug, but not more than $15 per prescription. In cases in which a brand-name maintenance drug is ordered through the ESI mail order facility even though it has not been specifically prescribed, ESI will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

As the Aetna prescription drug programme benefit is administered separately by Aetna Pharmacy Management, the annual deductible under the Aetna plan will **not** be applied to prescription drugs obtained at network pharmacies. At the same time, however, prescription drug co-payment expenses will **not** count towards meeting the annual co-insurance limit of $1,000. **Prescription drugs obtained at pharmacies in the United States, but not through network pharmacies, will be reimbursed at 60 per cent and be subject to deductible. In addition, the 40 per**

cent co-insurance amount will not count towards the annual $1,000 out-of-pocket limit. Prescription drugs obtained outside the United States will be reimbursed through submission of the standard claim form to the Aetna claims office in Allentown, Pennsylvania. In such cases, the annual deductible will have to be met before reimbursement is made, as well as the 20 per cent co-insurance, which will **not** count towards meeting the annual limit of $1,000.

Exclusions and other provisions

Special conditions apply to certain medical procedures for injury-related dental and cosmetic injury, for convalescent facility expenses and for treatment of temporo-mandibular joint syndrome (TMJ). Participants are advised to consult the Aetna claims office in advance of commencing treatment for these conditions.

Certain expenses are not covered under the Aetna plan. These comprise expenses for services or supplies not deemed by Aetna as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. In addition, inoculations for travel purposes are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Aetna as reimbursable under the plan, Aetna Member Services should be contacted at (800) 784-3991 prior to commencement of treatment. In addition, the Aetna policy contract document is on file in the offices of the Insurance Service and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

Aetna claims

The address to which Aetna claim forms should be sent is as follows:

Aetna U.S. Healthcare
Unit 73
3541 Winchester Road
Allentown, PA 18195-0513

Recourse if a claim is denied

If Aetna denies a claim in whole or in part, the subscriber will receive a written notice from Aetna. This notice will explain the reason for the denial and the appeal procedure. The request for review must be submitted in writing within 60 days of receipt of the notice. The subscriber should include the reasons for requesting the review and submit the request to the Aetna Allentown Claim Office. Aetna will review the claim and ordinarily notify the subscriber of its final decision within 60 days of receipt of the request. If special circumstances require an extension of time, notification will be given to that effect.

Time limit for filing claims

Subscribers should note that claims for reimbursement must be submitted to Aetna no later than two years from the date on which the medical expense was incurred. **Claims received by Aetna later than two years after the date on which the expense was incurred will not be eligible for reimbursement.**

Annex III

HIP Health Plan of New York (HIP)

Plan outline

The HIP plan follows the concept of total prepaid group practice hospital and medical care, that is, there is no out-of-pocket cost to the staff member for covered services at numerous participating medical groups in the Greater New York area. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. Additionally, prescription drugs (a $5 co-payment applies) and medical appliances (in full) are covered when obtained through HIP participating pharmacies and are prescribed by HIP physicians or any physician in a covered emergency. HIP participants may select a physician at a HIP medical centre or from a listing of 16,000 affiliated physicians for primary care services. The affiliated physician is visited in his or her private office. If you require specialty care, your primary care physician will refer you to a HIP specialist with a referral form. To select an affiliated physician, the HIP participant should call HIP at (800) HIP-TALK, go to the web site at www.HIPUSA.com or call the physician you wish to visit. Additional information regarding HIP providers will be provided to participants during the annual enrolment campaign and also mailed by HIP to all participants upon request.

Premium

The premiums and related percentages of salary contribution are shown on page 2 of the present circular.

Benefits

Benefits under the HIP plan will remain unchanged in the renewal period.

HIP benefits summary

Type of benefit	HIP coverage
Hospital services	Covered in full when authorized by a HIP- affiliated physician.
In-hospital physician's services	Covered in full when rendered by a HIP-affiliated physician.
Private duty nursing	Covered in full when authorized by a HIP-affiliated physician.
Skilled nursing facility	Covered in full when authorized by a HIP-affiliated physician.
Visits to physician's office/health centre	Covered in full at any HIP medical centre or if care is rendered by a HIP-affiliated physician.
House calls	Covered in full when authorized by a HIP-affiliated physician.
Maternity care	No waiting periods. Covered in full when care is rendered by a HIP-affiliated physician. Prenatal, post-natal and well-baby check-ups are covered in full up to age 19.
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when care is rendered by a HIP-affiliated physician. Eye examinations are covered in full when rendered by a HIP-affiliated provider (a $45 allowance is provided for eyeglasses every 2 years at HIP-affiliated providers. Hearing aids are excluded).
Mental health services: Call 888-447-2526 for a provider referral.	
In-patient	Covered in full for 30 days per calendar year for mental or nervous disorders.
Out-patient	Covered in full for 60 visits per year with HIP-affiliated providers.
	Individual, family or group therapy sessions are provided as long as treatment is effective. Intensive psychotherapy is excluded.
Alcoholism and substance abuse:	
In-patient	Covered in full for up to 30 days per year for rehabilitation. Detoxification is covered in full for 7 days per year.
Out-patient	Rehabilitation treatment covered in full up to 60 visits per year.

Type of benefit	HIP coverage
Emergency services:	
In-area/Out-of-area	Emergency care covered in full worldwide including ambulance. Call within 48 hours after care commences, either the HIP primary care physician, or directly to HIP at 888-447-2884.
	For an emergency physician referral in the U.S. only, call HIP at 800-223-0654.
Prescription drugs and medical appliances	Covered in full. $5 co-payment for prescription drugs when obtained at HIP participating pharmacies. The drugs and appliances must be prescribed by HIP-affiliated physicians or any physician in a covered emergency.
Preventive dental care	$10 co-payment for a semi-annual cleaning. $5 co-payment for a semi-annual oral examination. $5 co-payment for a semi-annual fluoride treatment for children to age 16. Members must use HIP-participating dentists for all care. Other dental procedures are discounted (see fees in the HIP dental handbook obtained from HIP).
Grievance procedure	Refer to member handbook sent to subscribers.

Annex IV

CIGNA Dental PPO Plan

Plan outline

The design of the CIGNA Dental PPO plan offers staff not only a large network of participating providers in the Greater New York metropolitan area and nationally, but also two distinct plan options, Option A and Option B, while retaining a single premium structure. The dual option structure is designed to ensure (a) that staff members have the dental treatment for themselves and their family members provided by a PPO network of dentists, and (b) that those staff members whose dental treatment is not rendered by network (or participating) dentists, will have the option of selecting a track which reimburses on the basis of a percentage of "reasonable and customary" dental fees, in much the same way as do the Aetna and Blue Cross PPO health plans. Please note that the CIGNA ID card does not indicate the option selected. The selection of either Option A or Option B is recorded in CIGNA's database and will be known to a provider at the time that coverage eligibility is checked by the provider's office.

Premium

The premiums and related percentages of salary contribution for the CIGNA plan are shown on page 2 of the present circular.

Benefits

Option A

Option A provides for 100 per cent coverage for most dental procedures without any deductible if the dental treatment is rendered by a dentist participating in the CIGNA provider network (a few dental procedures involving costly materials may require additional payment to the dentist by the participant). The CIGNA participating provider network is nationwide, and includes a total of over 38,000 dentists, with approximately 4,800 in New York State (3,000 in New York City), 2,100 in New Jersey and 700 in Connecticut.

Participants who choose Option A may also visit non-participating (or out-of-network) dentists and will be reimbursed the CIGNA in-network fee contracted with participating dentists who practice in the same area as the non-participating dentists. If the out-of-network dentist's fee is higher than the contracted in-network fee, the difference will be payable by the participant. It is important to note that, under the CIGNA plan, there is no single PPO contracted fee schedule. The contracted fee levels vary in accordance with prevailing costs in the different areas in which the dental practices are located. A chart summarizing the Option A benefits and reimbursement levels is set out on page 36.

Option B

The key feature of Option B is the reimbursement allowance formula for participants who wish to utilize out-of-network dentists. Under this option, out-of-network dental treatment will be reimbursed at certain percentage levels after an annual deductible of $50 per person or $150 per family has been met. The percentage reimbursement levels apply to the "reasonable and customary" dental fee

levels prevailing in the dentist's zip-code area. Reasonable and customary fee levels are determined by reference to a national database maintained by the Health Insurance Association of America (HIAA). The percentage reimbursement rate depends on the level of dental treatment as follows: 90 per cent for preventive/diagnostic treatment; 80 per cent for major and minor restorative treatment; 70 per cent for orthodontics.

Under Option B, participants may also be treated by in-network dentists. In this case there is no deductible. The reimbursement percentages for preventive/diagnostic care, major and minor restorative treatment and orthodontics are 100 per cent, 90 per cent and 80 per cent, respectively, based on the network provider's contracted fee level with CIGNA. Thus the amount payable by the participant will be the difference between the 90 or 80 per cent reimbursement and the CIGNA contracted PPO fee for the service provided. A chart summarizing the Option B benefits and reimbursement levels is set out on page 37.

Pre-treatment review (pre-determination of benefits)

If a course of treatment can reasonably be expected to involve covered dental expenses of $300 or more, a description of the procedures to be performed and an estimate of the dentist's charges should be filed with CIGNA before the course of treatment begins. The dentist should be sure to include the American Dental Association (ADA) procedure code for each procedure claimed. This process will inform the participant as to whether the proposed dental fee is within reasonable and customary norms (the Insurance Service has no information in this regard) and exactly how much will be reimbursed.

Dental treatment outside the United States

Participants who obtain dental treatment outside the United States may file their claims with CIGNA and are eligible for reimbursement on the same basis as a participant who visits a non-participating dentist in New York.

Maximum annual benefits

The annual benefit ceiling is $2,000 per covered person, and is the same for Option A and Option B. There is an additional lifetime allowance of $2,000 for orthodontic treatment, limited to dependent children up to 19 years of age.

CIGNA web site

Access to CIGNA's nationwide network of participating dentists is also available through the Insurance home page of the Insurance Service on the United Nations Intranet. In addition, the CIGNA dental provider directory can be accessed directly from the CIGNA Internet web site at: www.cigna.com/general/misc/docdir.html.

Benefit summaries

The benefit summaries on pages 36 and 37 highlight the many benefits which are available under the CIGNA Dental PPO plan.

How to appeal a claim

If you do not agree with the reason given for denial of your claim in whole or in part, you should write within 60 days to the CIGNA claims office. Be sure you state why you believe the claim should not have been denied and submit any data, questions or comments you think are appropriate. Your appeal will be reviewed by the office that processed your claim. Any appeal that cannot be resolved by that office will be forwarded to the company's Home Office for review and final decision. You will be notified of the final decision within 60 days of the date your appeal is received, unless there are special circumstances, in which case you will be notified within 120 days. If you are not satisfied with the final decision, and you wish to review the documents pertinent to any appealed claim, you should write to the office that processed your claim.

Benefit exclusions

The following list, while not necessarily complete, gives examples of benefit exclusions:

- Services performed solely for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge or denture within five years following the date of its original installation
- Replacement of a bridge or denture which can be made usable according to dental standards
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
- Bite registrations; precision or semi-precision attachments; splinting
- Surgical implant of any type, including any prosthetic device attached to it
- Instruction for plaque control, oral hygiene and diet
- Dental services that do not meet common dental standards
- Services that are deemed to be medical services
- Services and supplies received from a hospital
- Charges which the person is not legally required to pay
- Experimental or investigational procedures and treatments
- Any injury resulting from, or in the course of, any employment for wage or profit
- Any sickness covered under any workers' compensation or similar law
- Charges in excess of the reasonable and customary allowances

OPTION A

CIGNA DENTAL PPO SUMMARY OF BENEFITS

BENEFITS[a]	IN-NETWORK[b]		OUT-OF-NETWORK[b]	
Plan Year Maximum – 1 July 2001-30 June 2002 ***(Class I, II and III expenses)***	$2,000		$2,000	
Plan Year Deductible – 1 July 2001-30 June 2002	None		None	
Reimbursement Levels	Based on reduced contracted fees		Based on in-network reduced contracted fees	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I – Preventive & Diagnostic Care Oral Exams (two per year) Cleanings (two per year) Full Mouth X-Rays (one complete set every three years) Bitewing X-Rays (two per year) Panoramic X-Ray (one every three years) Fluoride Application (one per year for persons under 19) Scalants (Limited to posterior tooth for a person less than 14. One treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to relieve pain	100%	No Charge	100% of in-network contracted fee	Remainder of dentist's fee
Class II – Basic Restorative Care[c] Fillings Root Canal therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Extractions Oral Surgery	100%	No Charge	100% of in-network contracted fee	Remainder of dentist's fee
Class III – Major Restorative Care[c] Crowns Dentures Bridges	100%	No Charge	100% of in-network contracted fee	Remainder of dentist's fee
Class IV – Orthodontia Lifetime Maximum (in addition to the Class I, II and III maximum)	100% $2,000 Dependent children up to age 19	No Charge	100% of in-network contracted fee $2,000 Dependent children up to age 19	Remainder of dentist's fee

[a] Pre-treatment review (pre-determination of benefits) is strongly recommended when dental work in excess of $300 is proposed. The dentist deals directly with CIGNA in this regard.

[b] The $2,000 maximum is for the plan year, whether the provider is in-network or out-of-network, or a combination of the two.

[c] Some dental procedures involving costly materials may require additional payment by the participant to the provider.

OPTION B

CIGNA DENTAL PPO SUMMARY OF BENEFITS

BENEFITS[a]	IN-NETWORK[b]		OUT-OF-NETWORK[b]	
Plan Year Maximum – 1 July 2001-30 June 2002 (Class I, II and III expenses)	$2,000		$2,000	
Plan Year Deductible – 1 July 2001-30 June 2002				
Individual	None		$50 per person	
Family	None		$150 per family	
Reimbursement Levels	Based on reduced contracted fees		Based on Reasonable and Customary Allowances	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I – Preventive & Diagnostic Care Oral Exams (two per year) Cleanings (two per year) Full Mouth X-Rays (one complete set every three years) Bitewing X-Rays (two per year) Panoramic X-Ray (one every three years) Fluoride Application (one per year for persons under 19) Sealants (Limited to posterior tooth for a person less than 14. One treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to relieve pain	100%	No Charge	90%	10%
Class II – Basic Restorative Care[c] Fillings Root Canal therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Extractions Oral Surgery	90%	10%	80%[d]	20%[d]
Class III – Major Restorative Care[c] Crowns Dentures Bridges	90%	10%	80%[d]	20%[d]
Class IV – Orthodontia Lifetime Maximum (in addition to the Class I, II and III maximum)	80% $2,000 Dependent children up to age 19	20%	70%[d] $2,000 Dependent children up to age 19	30%[d]

[a] Pre-treatment review (pre-determination of benefits) is strongly recommended when dental work in excess of $300 is proposed. The dentist deals directly with CIGNA in this regard.

[b] The $2,000 maximum is for the plan year, whether the provider is in-network or out-of-network, or a combination of the two.

[c] Some dental procedures involving costly materials may require additional payment by the participant to the provider.

[d] Subject to plan year deductible.

Annex V

World Access

World Access (formerly known as Access America) is a facility available to Aetna and Empire Blue Cross subscribers. The $0.25 per month per subscriber cost of the World Access facility is built into the premium schedule for Aetna and Empire Blue Cross set out on page 2 of the present circular.

World Access provides an international travellers' 24-hour hotline assistance programme for obtaining medical care abroad, or within the United States, when at least 100 miles from one's normal place of residence. Participants who call the hotline numbers below will, where possible, be provided with referrals from a worldwide network of physicians, dentists, hospitals, pharmacies and other medical facilities. In addition, in most cases, World Access will settle the costs of emergency foreign hospital admission and treatment. If the emergency hospitalization occurs in the United States and the hospital does not accept the Aetna or the Empire Blue Cross PPO identification cards, World Access will also settle the related costs directly with the hospital and then claim reimbursement directly from Aetna or Empire Blue Cross as the case may be. In the case of hospitalization, World Access medical staff will contact the insured patient's local physician in order to monitor the case and services being received. In the event of an emergency hospitalization in the circumstances described above, it is important that World Access be contacted upon admission to the hospital or, at the latest, before discharge. It should also be emphasized that any hospital bill paid by the participant must be sent to Aetna or Empire Blue Cross for reimbursement, as World Access does not reimburse participants directly.

The hotline numbers are:

(800) 654-1901 (in the United States, Canada, Puerto Rico and the Virgin Islands)

(804) 673-1159 — collect (from Alaska, Washington, D.C. and all other locations), or

Fax No. (804) 673-1179 or (519) 742-8553

When contacting World Access, be sure to identify yourself as a United Nations participant. Please state the World Access identification number for the United Nations, which is 2065, in addition to your United Nations index number.

Annex VI

Aetna and Empire Blue Cross Plans: participating pharmacies

Aetna

The most up-to-date information regarding participating Aetna pharmacies is obtained through the Internet. Set out below is Aetna's Internet web site. In addition, if a participating pharmacy is needed while travelling, referral information is available from Aetna by calling 888-792-8742 toll-free.

www.aetnaushc.com/docfind/index.html

Empire Blue Cross

Empire's partnership with AdvanceRX includes more than 57,000 participating pharmacies nationwide. Listed below are just some of the major participating chain pharmacies. For additional information about participating pharmacies in your area, please call 800-839-8442.

A & P	Acme Pharmacy	Arbor
Bartell Drug	Bi-Lo	Bi-Mart
Big B	Biggs Pharmacy	Bolger Pharmacy
Brooks	Brookshire's	Costco
Cub Pharmacy	CVS	Dillons
Duane Reade	Eckerd	Epic Pharmacies
Finast	Genovese	Giant
Grand Union Pharmacy	Harvest Foods	K-Mart
Kash N Karry	Keystone/Medicine Chest	Kinney Drugs
Kroger	Mays	Medicap Pharmacy
Medisave	Pathmark	Rite Aid Pharmacy
Safeway	Sav-On Pharmacy	Shopko Stores
Shoprite	Snyder Drug Stores	Stop & Shop
Target	Thrift	Tops
Twin Valu Pharmacy	United Managed Care Pharmacies	United Supermarkets
Wal-Mart	Walgreens	

Annex VII

Eligibility and enrolment rules and procedures

1. All staff members holding appointments of three months or longer (or six months or longer for dental coverage) under the 100 series of the Staff Rules whose duty station is New York and who are not enrolled in a Headquarters medical/dental insurance plan may enrol during this annual campaign. Medical insurance provisions pertaining to technical assistance project personnel are set out under staff rule 206.4. Staff members holding appointments of limited duration under the 300 series of the Staff Rules, except those who receive a fixed monthly cash amount towards the cost of health insurance, are also eligible to enrol in line with the relevant provisions of administrative instruction ST/AI/2001/2, dated 15 March 2001. Currently enrolled staff members may take the opportunity of the annual enrolment campaign to review their coverage and change from one plan to another, or change their coverage in respect of members of their family. The medical scheme applicable to staff holding appointments of less than three months under the 100 series of the Staff Rules or who hold short-term appointments under the 300 series of the Staff Rules is administered by J. Van Breda & Co. International; information regarding this insurance programme can be obtained from the Insurance Service, room S-2765.

2. For enrolment purposes, applicants will be required to present proof of eligibility from their respective personnel or administrative officers attesting to their current contractual status. Eligible family members may also be enrolled at this time, provided that evidence of the status (Personnel Action form) of such family members is presented to the Insurance Service. Interested staff members should carefully review the current status of their family's enrolment, both as to the continued eligibility of their children and/or inclusion of those newly eligible or not covered at present.

3. "Eligible family members" refers to a spouse and one or more eligible children. A spouse is always eligible. A child is eligible to be covered under this scheme until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not engaged in full-time employment; disabled children may be eligible for continued coverage after the age of 25.

4. Staff members, particularly those who have no coverage under a United Nations plan or through another family member, are strongly urged to obtain medical insurance coverage for themselves and their eligible family members, especially since the high cost of medical care could result in financial hardship for individuals who fall ill and/or are injured and have no such coverage.

5. **In the case of a staff member married to another staff member, the insurance coverage, whether at the two-person or family level, must be carried by the higher-salaried staff member.** It should also be noted that if one spouse retires from service with the Organization before the other spouse, the spouse who remains in active service must become the subscriber even if the retired spouse had been the subscriber up to the date of retirement and is eligible for after-service health insurance benefits following separation from service.

Enrolment between annual campaigns

6. Between annual campaigns, staff members and their family members may be allowed to enrol in the Headquarters medical and dental insurance plans only if at least one of the following events occurs and application for enrolment is made within 31 days thereafter:

(a) In respect of medical insurance coverage, upon receipt of an initial appointment of at least three months' duration at Headquarters under the 100 or 300 series of the Staff Rules or upon appointment under the 200 series of the Staff Rules;

(b) In respect of dental insurance coverage, upon receipt of an initial appointment of at least six months' duration at Headquarters under the 100 or 200 series of the Staff Rules;

(c) Upon transfer to Headquarters from another duty station;

(d) Upon return from special leave without pay, but only under the health scheme in which insured prior to taking leave (see para. 9 below);

(e) Upon assignment to a mission, under certain conditions (see para. 10 below); and/or

(f) Upon marriage, birth or legal adoption of a child for coverage of the related family member;

(g) Upon the provision of evidence that the staff member was on mission or annual or sick leave for the entire duration of the annual campaign, staff members may enrol within 31 days of their return to Headquarters.

7. In all the cases cited in paragraph 6 above, the completed application for enrolment or re-enrolment must be certified by the appropriate personnel or administrative officer and received by the Insurance Service within 31 days of the occurrence of the event giving rise to entitlement to enrol. Applications and inquiries with regard to changes relating to such events occurring between campaigns should be directed to the Insurance Service as follows:

Insurance Service
Office of Programme Planning, Budget and Accounts
Room S-2765
United Nations Headquarters
New York, NY 10017

8. **Applications between enrolment campaigns based on any other circumstances or not received within 31 days of the event giving rise to eligibility will not be receivable by the Insurance Service and will be returned.** In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by the United Nations will in no case give rise to any right on the part of a staff member or family member to immediate enrolment in a United Nations plan. If such termination occurs between annual enrolment campaigns, the staff member must wait until the next campaign to enrol in a United Nations plan. Staff members who for any reason may be uncertain about the continuity of their outside coverage are urged to consider enrolling in a United Nations scheme during the present campaign.

Staff on special leave without pay

9. Staff members who are granted special leave without pay are reminded that they may retain coverage for medical and dental insurance during such periods or may elect to discontinue such coverage for the period of the special leave:

(a) *Insurance coverage maintained during special leave without pay*. If the staff member decides to retain coverage during the period of special leave without pay, the Insurance Service must be informed directly by the staff member of his or her intention at least one month in advance of the commencement of the special leave, in person if at Headquarters, or in writing if stationed away from Headquarters. At that time, the Insurance Service will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage(s) retained (both the staff member's contribution as well as the Organization's share, since no subsidy is payable during such leave);

(b) *Insurance dropped while on special leave without pay*. Should a staff member decide not to retain insurance coverage(s) while on special leave without pay, no action is required upon commencement of the special leave;

(c) *Re-enrolment upon return to duty following special leave without pay*. Regardless of whether a staff member has decided to retain or drop insurance coverage(s) during a period of special leave without pay, it is essential that he or she re-enrol in the plan(s) with the Insurance Service upon return to duty, in person if at Headquarters, or in writing if away from Headquarters. This must be done **within 31 days of return to duty**. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan(s) until the next annual enrolment campaign in the month of June.

Staff members assigned on mission

10. In view of the large number of staff members who go on mission assignment, a special medical/dental plan enrolment opportunity is extended to such staff members. The provisions in this respect, which will apply to all staff members going on mission for six months or more, are as follows:

(a) Staff members who at present are not enrolled in any United Nations health insurance plan will be allowed to enrol themselves and eligible family members. The insurance will become effective on the first day of the month in which the mission assignment commences. Enrolment in a health insurance plan in these circumstances must be completed prior to the departure of the staff member on mission assignment;

(b) Staff members assigned to a mission who are enrolled in HIP, a plan which does not offer full services at locations away from Headquarters, may switch to either Aetna or Empire Blue Cross. These two plans provide benefits on a worldwide basis. Enrolment in the Aetna or Empire Blue Cross plans under this provision must be completed prior to the departure of the staff member on mission assignment;

(c) Staff members who, at the time of commencement of the mission assignment, do not have dental coverage but who are already enrolled, together with eligible family members, in Aetna or Empire Blue Cross, may enrol themselves and

family members covered under their medical insurance plan in the dental plan. Such enrolment must be completed prior to the departure of the staff member on mission assignment;

(d) Staff members who elect to enrol in a health insurance plan in the circumstances provided under subparagraphs (a) to (c) above forgo the right to make any further change during the annual enrolment campaign taking place in the same calendar year as the commencement of the mission assignment. The next opportunity for these staff members to make any change in their insurance coverage will be at the time of the annual enrolment campaign of the following year;

(e) Staff members who are already enrolled in Aetna or Empire Blue Cross at the time of the mission assignment must retain their existing coverage until the next annual enrolment campaign;

(f) Staff members who will be on mission assignment for six months or more **and who will not have eligible covered family members residing in the United States** for the duration of the mission assignment may opt for coverage under the Van Breda Medical, Hospital and Dental Insurance plan for staff overseas. Details of this plan are available in the offices of the Insurance Service, room S-2765;

(g) Staff members returning to Headquarters from mission assignment, other than those who qualified and opted for the Van Breda plan, may not change their insurance coverage until the next annual enrolment campaign. **Staff members who switched to the Van Breda plan, as provided under subparagraph (f) above, must revert, upon return to Headquarters, to the insurance plan that they had prior to the mission assignment, at least until the next annual enrolment campaign.** It is essential that such staff members advise the Insurance Service within 31 days of their return to Headquarters. **Failure to re-enrol in the prior Headquarters plan within 31 days of return to duty from mission assignment will result in suspension of health insurance coverage.**

11. **In all cases, staff members going on mission assignment who wish to enrol in a health insurance plan or change their present coverage, as provided above, must present evidence to the Insurance Service of the mission assignment and its duration.**

Annex VIII

Insurance carrier addresses and telephone numbers for claims and benefit inquiries

I. Aetna "Open Choice" Plan (medical and out-of-network pharmacy claims)

Aetna U.S. Healthcare
Unit 73
3541 Winchester Road
Allentown, PA 18195-0513

Tel.:	(800) 784-3991	Member Services (benefit/claim questions)
Tel.:	(800) 333-4432	Pre-registration of hospital/institutional services
Tel.:	(888) 792-8742	Participating pharmacy referral
Tel.:	(877) 849-5521	Express Scripts (ESI) (mail order drugs)
Tel.:	(888) 792-8742	Maintenance drug automated refills (credit card)
Tel.:	(800) 424-1601	Focused Psychiatric Review (FPR)
Tel.:	(800) 793-8616	Vision One

II. Empire Blue Cross PPO Plan

Empire Blue Cross Blue Shield
PPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Tel.:	(800) 342-9816	Member Services (benefit/claim questions)
Tel.:	(800) 982-8089	Medical Management Program (pre-certification for hospital admissions, elective surgery, home care, skilled nursing facilities, second opinion referrals)
Tel.:	(800) 626-3643	Behavioral Health Care Management Program (prior approval of mental health/substance abuse care)
Tel.:	(888) 266-5691	AdvanceRX (maintenance drug mail order)
Tel.:	(800) 839-8442	Empire Pharmacy Management Program/AdvanceRX (prescription card programme and pharmacy network information)
Tel.:	(888) EYE-BLUE {(888) 393-2583}	Davis Vision (vision care programme)

III. HIP

HIP Member Services Department
7 West 34th Street
New York, NY 10001

Tel.: (800) HIP-TALK {(800) 447-8255}

IV. CIGNA Dental PPO Plan

CIGNA Healthcare Service Center
P.O. Box 188003
Chattanooga, TN 37422-8003

Tel.: (800) 355-5965 claim submission, ID card requests and customer service

Tel.: (888) DENTAL8 for participating provider referrals

V. World Access

Tel.: (800) 654-1901 (in the United States, Canada, Puerto Rico and the Virgin Islands)

Tel.: (804) 673-1159 (collect from Alaska, Washington, D.C. and all other locations)

Fax: (804) 673-1179 or (519) 742-8553